MEDICAID ESTATE RECOVERIES

National Program Inspection

OFFICE OF INSPECTOR GENERAL
OFFICE OF ANALYSIS AND INSPECTIONS

JUNE 1988

Office of Inspector General

The mission of the Office of Inspector General (OIG) is to promote the efficiency, effectiveness and integrity of programs in the United States Department of Health and Human Services (HHS). It does this by developing methods to detect and prevent fraud, waste and abuse. Created by statute in 1976, the Inspector General keeps both the Secretary and the Congress fully and currently informed about programs or management problems and recommends corrective action. The OIG performs its mission by conducting audits, investigations and inspections with approximately 1,200 staff strategically located around the country.

Office of Analysis and Inspections

This report is produced by the Office of Analysis and Inspections (OAI), one of the three major offices within the OIG. The other two are the Office of Audit and the Office of Investigations. The OAI conducts inspections which are, typically, short-term studies designed to determine program effectiveness, efficiency and vulnerability to fraud or abuse.

This study was conducted to evaluate State Medicaid estate recovery programs, document best practices, and recommend enhancements.

The report was prepared under the direction of Kaye D. Kidwell, the Regional Inspector General of Region IX, Office of Analysis and Inspections. Participating in this project were the following people:

- Stephen A. Moses, Project Director
- Kathy L. Admire, Program Analyst
- Leonard Czajka, Program Analyst
- Ruth E. Carlson, Program Assistant
- Jeffrey Balentine, Project Liaison, Headquarters
- Norm Zimlich, Former Project Director, now with the State of Washington

MEDICAID ESTATE RECOVERIES

RICHARD P. KUSSEROW
INSPECTOR GENERAL

JUNE 1988

OAI-09-86-00078

EXECUTIVE SUMMARY

PURPOSE: The purpose of this study was to:

- Evaluate the extent and effectiveness of Medicaid estate recovery programs implemented pursuant to the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982.
- Document State statutory authorities, methods, best practices and problems related to the recovery of benefits correctly paid from the estates of deceased Medicaid recipients.
- Solicit and report the advice of States concerning the best Federal approach to improving Medicaid estate recoveries.

BACKGROUND: The TEFRA authorized States to (1) restrict transfers of assets for purposes of obtaining Medicaid eligibility, (2) place liens on the real property of Medicaid recipients to insure the property's availability for later recovery and (3) recover the cost of care from the estates of deceased recipients. Evidence from many sources--including law journal articles, the popular media, the National Governors' Association, State Medicaid programs, and an unpublished Health Care Financing Administration (HCFA) study--suggest that the new TEFRA authorities may be less than fully effectual.

MAJOR FINDINGS: Although Medicaid covers only about one-third of poor people over age 65, many elderly recipients retain sizeable estates which pass to their heirs without reimbursement of public costs.

Only 23 States and the District of Columbia recover benefits correctly paid from the estates of deceased Medicaid recipients. They recover less than $42 million annually. Cost effectiveness ratios range from less than $2 to over $51 recovered for every dollar invested. If every State recovered:

At the same level of effectiveness as:	Then, the national recovery potential would be:
The most effective State (Oregon)	$589 million
The mean of current recovery States	$ 74 million
A large, urban State (California)	$123 million

The States report that Medicaid eligibility rules permit knowledgeable individuals to transfer or shelter property from Medicaid resource limitations in a manner reminiscent of income tax avoidance. Less savvy applicants are denied eligibility and have to liquidate their assets and spend down to Medicaid limits at great inconvenience and financial loss to their families. Whether assets are transferred or liquidated, they are lost as a future source of revenue to the Medicaid program through estate recoveries.

Despite congressional intent that "resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the costs of supporting the individual in the institution," only two States have implemented TEFRA's lien provisions to secure property for estate recovery.

Many State Medicaid staff believe that program resources could be enhanced and inequities reduced by (1) stronger restrictions against transfer of assets to qualify for assistance, (2) fewer restrictions against the use of liens to secure property for estate recovery and (3) mandatory estate recovery programs.

RECOMMENDATIONS: We recommend that appropriate actions be taken to:

- Change Medicaid rules to permit families to retain and manage property while their elders receive long-term care.

- Strengthen the transfer of assets rules so that people cannot give away property to qualify for Medicaid.

- Require a legal instrument as a condition of Medicaid eligibility to secure property owned by applicants and recipients for later recovery.

- Increase estate recoveries as a nontax revenue source for the Medicaid program while steadfastly protecting the personal and property rights of recipients and their families.

- Conduct (a) a thorough audit of current estate recovery programs, (b) a study to determine how much equity is being diverted through liquidation or transfer of assets from long-term care costs at the expense of the Medicaid program, and (c) a review to evaluate how large a chilling effect the availability of Medicaid without encumbering assets has on the marketability of private risk-sharing solutions like long-term care insurance.

AN ANALYSIS OF THE MEDICARE CATASTROPHIC BILL IN THE CONTEXT OF THE OFFICE OF INSPECTOR GENERAL'S REPORT ON MEDICAID ESTATE RECOVERIES

The Medicare Catastrophic Loss Prevention Act of 1987 (H.R. 2470) as passed and amended by the Senate on October 27, 1987 (S. 1127), contains several provisions related to matters discussed in this report. The germane section of the catastrophic bill is "SEC. 14C. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE." This section would make two major changes to the Social Security Act in addition to requiring the Secretary of Health and Human Resources to conduct a major national study. The first change would add a new section 1921 to the act entitled "TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES." The purpose of this section is to ameliorate the spousal impoverishment problem. The second change, entitled "TAKING INTO ACCOUNT CERTAIN TRANSFERS OF ASSETS," would amend subsection (c) of section 1917 of the act to require a Medicaid State plan provision delimiting transfers of assets to qualify for assistance. Finally, the bill would require the Secretary to conduct a study of Medicaid estate recoveries. We will discuss each of these provisions in sequence.

Spousal Impoverishment

Under current law, spouses of institutionalized Medicaid recipients are sometimes forced into impoverishment by Medicaid eligibility rules. This usually occurs because the husband is institutionalized first. If, as is often the case, most of the family's income such as Social Security and/or a pension is in the husband's name, Medicaid rules provide that all but a small amount must be applied toward his cost of care. The wife who is left in the home, i.e., the community spouse, retains only a pittance. On the other hand, if the wife is institutionalized first, and the income is still in the husband's name, he keeps the money, because the community spouse has no legal obligation to contribute toward the cost of the institutionalized spouse's care.

The catastrophic bill addresses this problem by increasing the amount of income and resources that the community spouse may retain without affecting the Medicaid eligibility of the institutionalized spouse. Because more people would qualify for assistance and less family income would apply toward the cost of institutional care, the fiscal impact of this solution would be to increase Medicaid expenditures. We found

that 3-year cost estimates on similar provisions in different bills varied from $410 million (Congressional Budget Office) to $1,275 million (HCFA actuaries) depending on implementation assumptions. All estimates ascend steeply into future years.

Certain findings from the OIG's Medicaid Estate Recoveries report have a direct bearing on the spousal impoverishment issue. In fact, we believe this problem can be resolved at considerably less public expense than is comtemplated in the current legislation. We found, for example, that many "impoverished spouses" own their homes free and clear. Their problem is cash flow, not poverty per se. We found that two-thirds of the elderly poor are unable to qualify for any Medicaid services, although many individuals with large assets are eligible for the program's most valuable benefit (i.e., institutional care). We documented that recovery of Medicaid payments from the estates of property-holding recipients is very unusual. This is true because assets are (1) transferred, sheltered, expended or concealed by recipients and their families and/or (2) public officials have taken no action to recover. In light of these facts, we recommended that propertied recipients be permitted to retain their income and assets while receiving Medicaid long-term care benefits, but only in exchange for a promise, secured by a legal encumbrance, to repay the cost of their care when they no longer need their property. This repayment would be made from their estates or the estates of their last surviving dependent relatives after the property is no longer needed for a livelihood. Such a plan would resolve the spousal impoverishment problem, eliminate the most catastrophic financial impact of long-term illness, and add a major nontax revenue source for Medicaid. More importantly, the risk of losing their financial legacy would influence the elderly and their heirs to seek private long-term care insurance protection and thus further relieve fiscal pressure on public programs.

Transfer of Assets

The catastrophic bill would make several changes in the handling of asset transfers to qualify for Medicaid. Transfers to a community spouse up to but not exceeding a newly created "resource allowance" would be allowed. Transfers in any amount pursuant to a court order would be permitted. Finally, a State plan amendment would be required which delays eligibility for a period of time commensurate with the amount of uncompensated value transferred within 26 months of application for Medicaid.

In most other respects, the transfer of assets restrictions would remain the same as in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

The OIG report contains a considerable body of evidence relevant to these legislative proposals. For example, assets transferred to a spouse or any other exempt dependent may then be transferred by the grantee to someone else such as an adult child or a charity without affecting Medicaid eligibility. As a consequence, even very large estates are eliminated forever as a source of private funding for long-term care. This welfare resource avoidance technique is widely recommended by lawyers who counsel the well-to-do elderly on how to qualify for Medicaid. We also discovered many other similar techniques. For example, community spouses (and adult heirs and their attorneys) sometimes (1) seek court ordered support from spouses institutionalized at Medicaid's expense, (2) obtain divorces to impoverish the ill spouse, (3) set up Medicaid qualifying trusts, (4) fail to disclose property or transfers, (5) purchase exempt property to shelter liquid assets, (6) relocate institutionalized elders to States with more lenient eligibility rules, (7) deed homes and automobiles over to themselves and (8) use joint tenancy ownership as a shelter. These actions and many others are taken to preserve income and assets for the family by shifting long-term care expenses to Medicaid. Finally, we found that the practice of transfering assets to qualify for Medicaid is quite common even though all States but one already have rules restricting such transfers. In other words, making transfer of assets rules mandatory will not alone resolve the problem.

Perhaps our most important finding on asset transfers, however, is that they are not nearly as important as another Medicaid "loophole." A much larger source of private long-term care funding is lost because of the relatively obscure "intent to return" rule than will ever be lost because of asset transfers. The home of an institutionalized Medicaid recipient who expresses an intent to return home remains exempt indefinitely whether or not such a return is medically feasible. Thus, people do not have to transfer assets to protect their property for heirs. Unless the State has an effective estate recovery program, and this is unusual, an exempted home inures to the heir upon the death of the recipient. With 70 percent of the net worth of the elderly invested in their homes, the intent to return rule means that most of this wealth is easily protected from long-term care costs and preserved for heirs at public expense.

We do not advocate forcing families to sell their homes to pay for nursing home care. This is done in many States despite the "intent to return" rule. We believe the practice is uneconomical as public fiscal policy as well as financially devastating to impacted families. Rather, we propose to let families, including community spouses, keep their real and liquid assets subject to a promise to repay Medicaid benefits from their estates. Recipients or heirs who wish to protect estates may purchase private long-term care insurance to do so. With such requirements in place, demand for, and hence availability of, this insurance can be expected to increase rapidly. The rules requiring estate recovery could be grandfathered in to safeguard individuals who are already too old or infirmed to obtain long-term care insurance in the private market place. In this manner, we can protect more people from catastrophic long-term care costs at less public expense.

Medicaid Estate Recoveries Study

The catastrophic bill provides that the Secretary shall conduct a "study of means of recovering costs of nursing facility services from estates of beneficiaries." A report to Congress on this study would be due by December 31, 1988. We believe that it is important to observe that three major studies on this subject have already been conducted. The first research project was done by the Health Care Financing Administration's Seattle Regional Office. Although unpublished by HCFA, this study spurred major national reviews of estate recoveries by both the Office of Inspector General and the General Accounting Office (GAO). The GAO report is due for publication in 1988 and is expected to corroborate the OIG's findings. If the OIG report is correct, Medicaid estate recovery programs are relatively easy to implement and highly profitable for State and Federal treasuries. The IG estimates that each year we delay implementing estate recoveries may cost the taxpayers as much as $500 million even under current law. With enhancements to current law as recommended in the OIG report, savings could be much higher still.

TABLE OF CONTENTS

Page

EXECUTIVE SUMMARY i

AN ANALYSIS OF THE MEDICARE CATASTROPHIC BILL IN THE CONTEXT OF THE OFFICE OF INSPECTOR GENERAL'S REPORT ON MEDICAID ESTATE RECOVERIES . . iii

INTRODUCTION 1

FINDINGS

TRANSFER OF ASSETS 4
State Statutes on Transfer of Assets 5
State Procedures 6
How Transfer of Assets Provisions Affect People 7
The Intent to Return Rule 10
State Staff Speak Out on Transfer of Assets Problems 12
State Recommendations 15

WHY PEOPLE WITH SIZEABLE ESTATES END UP ON MEDICAID 16

LIENS 18
Problems With Liens 19
Alternatives to Liens 22
State Recommendations 22

ESTATE RECOVERIES 23
State Performance 24
Chart: Medicaid Estate Recovery Programs by Type of Program 25
Table 1: Active Medicaid Estate Recovery Programs 27
Estate Recovery Effectiveness Ratios 28
Table 2: Effectiveness Measures 30
National Projections 31
Table 3: National Estate Recovery Projections 31
Organization and Procedures 32
Chart: Medicaid Estate Recoveries: Actual and Potential for United States . . 33
Spousal Recoveries 36
Other Practices 37
Accounts Receivable 37
Exemplary Practices 38
State Statutes 39
Table 4: State Characteristics 40
State Recommendations on Estate Recoveries . . 44

CONCLUSION 46
Illustration: Tip of the Iceberg 49

RECOMMENDATIONS 50

BIBLIOGRAPHY 54

APPENDIX A-1

INTRODUCTION

The Federal Medicaid statute passed in 1965 severely limited State authority to restrict asset transfers, impose liens, or recover the cost of care from recipients' estates (Deford, p. 134). For many years, anyone in need of long-term care could give away everything and qualify for nursing home institutionalization paid for by Medicaid without any concern for repayment.[1] Then, in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Congress enacted a three-pronged plan intended

> to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in the institution. (U.S. Code, p. 814)

The TEFRA allowed States to (1) count the uncompensated value of an asset transferred for less than fair market price toward the Medicaid eligibility resource limits, (2) place liens on the property of living recipients to insure the availability of the property in their estates and (3) recover the cost of benefits correctly paid from the estates of deceased recipients. These new authorities were restricted in many critical ways as we will discuss below. In theory, however, if States chose to exercise the new TEFRA authority, people would no longer be able to jettison property, nor have it divested by others, to qualify for Medicaid. States could recover the cost of care from the retained property when it was no longer needed by the recipients or their dependents. Furthermore, the recovered funds could be used to help other people in their time of need.

In the fall of 1985, the Office of Inspector General became aware of information which brought into doubt the effectiveness of the new TEFRA procedures. We reviewed a draft report prepared by region X of the Health Care Financing

---

[1] There was no Federal authority to restrict transfers of assets to qualify for assistance. Some States restricted asset transfers anyway, and this led to litigation. The Boren-Long Amendment of 1980 was supposed to resolve the problem. It permitted States to restrict asset transfers, but only if the assets transferred were nonexempt. Thus, Boren-Long excluded most recoverable assets from transfer of assets restrictions.

Administration (HCFA). This unpublished report[2] explained (1) how people even with large assets can qualify for Medicaid, (2) how "loopholes" in TEFRA's transfer of assets, lien and estate recovery authority weakened the law's impact, and (3) what might be done to achieve the original congressional objectives without sacrificing important safeguards. The report contained extensive documentation: excerpts from legal journals recommending Medicaid eligibility resource avoidance as a routine estate planning technique; information on transfer of assets, lien, and estate recovery practices around the country; analysis of recovery practices in 2 diverse States; and over 140 actual case examples of the impact of these policies on recipients' lives and Medicaid program resources. Finally, the HCFA draft projected a large nontax revenue source to the Medicaid program, based on actual results in one very successful State, if the TEFRA provisions were uniformly and efficiently implemented nationally.

Faced with strong evidence of a potentially large new nontax revenue source, we decided to find out exactly what States have done since 1982 to implement TEFRA's asset control authorities. We sought to determine the extent and effectiveness of Medicaid estate recovery programs throughout the country. We wanted to report on "best practices" that could be used in other States. We also saw the need to examine State Medicaid eligibility policy with regard to transfer of assets and liens, because estate recoveries are obviously moot if no property is retained in recipients' possession that can be recovered after their deaths. To obtain the necessary information, we used a questionnaire which was reviewed in advance by HCFA and approved by the Executive Office of Management and Budget (EOMB). All 50 States and the District of Columbia responded. We did extensive telephone follow-up with about three-fourths of the respondents.

Almost simultaneously with our work, the General Accounting Office (GAO) in region X undertook a national study of TEFRA's asset control provisions with a focus on estate recoveries. The GAO's emphasis is on actual dollar recovery potential in eight States based on review of statistically valid case samples. Its study is due for publication sometime in 1988. We have met frequently, worked closely, and shared extensively with GAO staff on this project. The collaboration was very beneficial.

---

[2] Some of the material in the HCFA report was published in a volume entitled, "Medicaid Transfer of Assets" in October 1985.

Others who have studied this subject are Russ Hereford and Bruce Spitz of Brandeis University, Gill Deford of the National Senior Citizens Law Center, Rick Curtis and John Luehrs of the National Governors' Association (NGA) Center for Health Policy Studies, and the Office of Inspector General, Office of Audit. Hereford and Spitz wrote the first, path-breaking paper on transfer of assets in December 1983. In June 1984, Deford published the most thorough legal analysis of "Medicaid Liens, Recoveries and Transfer of Assets After TEFRA" available to this day. Curtis and Luehrs at NGA have examined and compiled the literature, interviewed State officials, and offered a sounding board and clearing-house on transfer of assets policy.

FINDINGS

Our study began with a definite focus on estate recoveries. We realized quickly, however, that the TEFRA asset control authorities are an integrated tripartite package. Transfer of assets, liens and estate recoveries are inextricably linked. They are the tools Congress gave the States to secure a person's property before and during Medicaid eligibility so that equity in the property can help pay, after death, for the person's cost of care. Therefore, we will present our findings in the following order: transfer of assets, liens, recoveries. Each section (a) begins with a brief explanation of the law, followed by a discussion of the relevant questionnaire responses, and (b) includes examples and descriptions of best practices used in various States. The report concludes with a summary of estate recovery activity and an estimate of the recovery potential nationally with and without changes to the Social Security Act.

TRANSFER OF ASSETS

Section 1917(c) of the Social Security Act codifies TEFRA's transfer of assets provisions. It says that

> ...an individual who would otherwise be eligible for medical assistance under the State plan...may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value.

Having granted this authority, the remainder of the section restricts its scope. With regard to institutionalized recipients who must contribute most of their income to the cost of their care, i.e., the nursing home population most likely to possess excluded assets who are the principal subjects of this study, the law provides:

1. The "look back" period for a home transfer at less than fair market value is limited to 2 years immediately before the Medicaid application.[3]

---

[3] A HCFA Memorandum dated July 31, 1986, from the Acting Director of the Bureau of Eligibility, Reimbursement and Coverage (BERC) to the Regional Administrator of HCFA's Atlanta Region (IV) conveyed an unexpected interpretation of the law. According to BERC, "If an individual may be made ineligible for more than 24 months, there is no reason to believe that a State may not look back for the same period

2. The period of ineligibility after disposal of the home may be less than 2 years or more, but it must bear a "reasonable relationship...to the uncompensated value of the home."

3. Ineligibility may not be imposed if the individual

   - is expected to return home,
   - transferred the home to a spouse or minor or disabled child, or
   - intended to dispose of the home for fair market value.

4. Ineligibility may not be imposed if the State determines that "denial of eligibility would work an undue hardship."

Because the act specifies that Medicaid limitations on transfer of assets may not be more restrictive than Supplemental Security Income (SSI) limitations, except under specified conditions which do not apply to this point, ineligibility will also not occur if an individual or spouse "furnishes convincing evidence" that an otherwise disqualifying transfer was done "exclusively for some other purpose" than to become eligible for assistance.

The law on transfer of assets is extremely complex, confusing, and litigable. Although HCFA has not yet published regulations to clarify the statutory language, such regulations are under development.

According to our questionnaire responses, 49 States have opted to apply the transfer of assets restrictions. Alaska did not. Assets may be given away with impunity to qualify for Medicaid in that State.

State Statutes on Transfer of Assets

Some States have their own statutes dealing with transfer of assets. These vary widely in strength. Alabama makes an

---

of ineligibility to determine whether there was a transfer of assets for less than fair market value which would have made the individual ineligible at the time of the transfer." Deford disagreed strongly with such an interpretation (Deford, p. 138). Only the courts can decide definitively whether look-backs beyond 2 years are permissible under these special circumstances. In practice, however, such circumstances occur infrequently.

"inter-vivos" gift of assets void if the donor is left without means of support. Connecticut law makes transfer of property for less than fair market value for purposes of obtaining assistance a fraudulent conveyance and provides for civil action. Virginia makes recipients of such property liable for the uncompensated value. Illinois says the transfer of money or property of a current or former recipient into a joint tenancy account is "prima facie evidence of an intent to defeat the claim against his estate." Oregon law authorizes the State to (1) petition for judicial appointment of a conservator to protect incapacitated recipients from inappropriate or victimizing divestitures and (2) "prosecute a civil suit or action to set aside the transfer, gift, or other disposition of any money or property made in violation" of transfer of assets rules. At the other end of the spectrum are Montana and several other States which do not apply transfer of assets restrictions to property which is exempt or would have been exempt if the grantor had been on assistance at the time of the transfer. Finally, one person responded that "the general tone in [my State] is that it is ethical and appropriate to rearrange assets to insure an inheritance for heirs. What often happens at the time of death is that there is no estate to open. The family can distribute and move assets so nothing is left.... It is seen as appropriately conserving assets for the dearly intended."

Most States which restrict transfer of assets follow the Federal statute's prescriptions and HCFA policy regarding the 2-year look-back period. A few do not. Four States use a 5-year look-back; two States use 3 years; and two States use 1 year.

State Procedures

All States utilize a document, i.e., the Medicaid application, which describes assets and their value and which must be signed by the applicant. Home equity, normally the applicant's largest asset, is usually not recorded, however, if the home is exempt at the time of application. The failure of eligibility workers to place a value on exempt homes was roundly criticized by one estate recoveries official. Exempt property can become nonexempt, e.g., when a resident spouse dies, and may be recoverable from an estate. For this reason, all property is important even if it does not immediately obstruct eligibility. Many States, including some active in estate recoveries such as California, Montana and North Dakota, do not apply transfer of assets restrictions to exempt property. In such States, a recipient can transfer exempt property to a third party, receive long-term care benefits for the rest of his life, and never have to worry about recovery from the estate.

Nearly all States do routine training for eligibility workers on treatment of resources including transfer of assets. Only three States reported doing special training on transfer of assets and/or estate recoveries. One State alone, Oregon, routinely provides annual training for field staff on the importance of and the relationship between enforcing transfer of assets provisions and recovering from estates.

Based on the assumption that transfer of assets restrictions are moot if States are unaware of the asset or transfer, we asked about routine verification procedures to determine if liquid assets and real property were investigated even if denied by the applicant. We found that 39 States independently verify assets, usually by contacting banks. Only 18 States, however, routinely check with county assessors and recorders concerning home ownership and transfers. Verification of the real property of nursing home recipients is by far the most important procedure, because most of the net worth of the elderly is in their homes. Liquid assets, we were told, are so easy to dispose or convert to excluded resources that they hardly matter. Real property, on the other hand, is registered and relatively difficult to hide or convert. Some States said that checking for property in all cases was time-consuming and unproductive. One State made a very telling remark which presages what follows in this analysis: "So many transfers are legitimate, there is no use checking." Nevertheless, a single "hit" which disqualifies an ineligible recipient or results in a recovery of benefits paid can justify considerable looking. Oregon estimates that a full-time employee could be profitably employed verifying nothing but foreign (i.e., out of State) property which was unreported by recipients. It "recently tracked down a property sold by a family in Massachusetts who then put their elder [who had owned the property] in a nursing home in Oregon on Medicaid and moved to Arizona." California actually keeps property records on microfiche in their office. The records are obtained from a Florida company which compiles such information.

How Transfer of Assets Provisions Affect People

To understand better how transfer of assets restrictions affect people, we asked what options are given to an applicant or recipient if the State discovers a disqualifying transfer. In almost all States, there are no options. The person receives due process in the form of an opportunity to rebut, appeal, or argue hardship. The uncompensated value of disposed assets is counted toward the personal asset reserve standard. Then the application is denied or the current eligibility terminated if appropriate. An applicant or recipient may reverse the disqualifying transfer or

obtain full compensation, but these alternatives usually cause ineligibility anyway because of excessive resources. The next step is to determine a period of ineligibility which may be shortened based on high medical costs, urgent home repairs, or other justifiable expenditures.

A few States offered some creative options to the transfer of assets dilemma. Recipients disqualified after a period of receiving inappropriate benefits might be permitted to repay the cost of their care as in Alabama, Colorado and Oregon, in order to shorten their periods of ineligibility and minimize their exposure to higher, private-pay nursing home rates. "Avoiding probate" might be accepted as a valid rebuttal of the presumption that a transfer was for the purpose of obtaining Medicaid eligibility as in California and Idaho. Or perhaps the State would intercede on behalf of the client to reverse a victimizing transfer and seek financial recourse from the grantees. Colorado, Connecticut and Oregon will do this in cases of financial abuse. The most creative option to the transfer of assets dilemma, however, is Oregon's "open ended mortgage." Grantees, i.e., the people to whom recipients have given their assets, are permitted to retain the transferred property. In exchange, however, they must agree to pay back the full cost of Medicaid benefits upon the recipient's death up to the uncompensated value of the property secured.

Several States lamented HCFA and SSI policies on "contracts for deeds,"

> "Until recently, Minnesota allowed people to keep their contracts and the income would apply toward their cost of care in a nursing home under Medicaid. Now, we have to treat the contracts as disqualifying property. That means the people have to sell the contracts at a severe discount. This value is lost to the recipient, the State and the Federal Government. Then the recipient ends up back on Medicaid in a short time anyway. If the contracts were kept, they would go on paying even after the recipient dies, frequently paying the whole cost of care sooner or later."

For example, says Utah:

> "A person sells their $50,000 home and this generates $500 a month for 30 years--that's $180,000 we could use toward the cost of nursing home care. The SSI regs say we have to count this as an asset, so the recipient sells the contract for $20,000, which makes him ineligible for 1 or 2 months, and then he's right back on Medicaid,

> when we could have been applying the $500 per month almost indefinitely. The Medicaid program would be much better off, if we could have continued to operate allowing recipients to keep their contracts, but HCFA says we have to count these as an asset."

Colorado concurs. At least one other State, sharing these concerns, simply ignores the HCFA/SSI rules without being challenged, a not uncommon State strategy on eligibility policy compliance issues.

One other option available to Medicaid applicants with disqualifying assets or transfers has been eliminated by departmental policy. Until September 1985, SSI and HCFA allowed recipients to receive benefits while they made a "bona fide effort to sell" their excess resources.[4] Now, recipients must liquidate their resources and spend down to eligibility limits before they can be eligible.[5] The States often observed that this new policy can lead to "fire sale" liquidations, loss of asset value, and family disruption. According to Connecticut, "By forcing this kind of loss, Medicaid is just enriching someone else at the expense of the client, the State and the Federal Government."

We asked how States handle this situation with regard to home property. Thirty-seven States said that, in the absence of some other reason to exempt the home, it would have to be sold and the proceeds spent. Thirteen of these States reminded us that another reason to exempt the home, i.e., the "intent to return" rule discussed below, is almost always available. Eight States, however, made some reference to an extended exemption based on the effort to sell a nonexempt resource despite the policy restriction on such exemptions. Some States permit eligibility if the recipient agrees to pay back benefits received when the property is sold and is willing to secure this responsibility with a lien or assignment on the property. Other States do not require the lien and may or may not require a pay back. Connecticut allows an applicant with disqualifying resources

---

[4] The sources for this statement are a HCFA Memorandum dated September 20, 1985, and Transmittal No. 14 of the Supplemental Security Income (SSI) Program Operations Manual System (POMS) dated November 14, 1985.

[5] The Omnibus Budget Reconciliation Act of 1987 has partially reinstated "bona fide effort to sell."

to "sign a mortgage with the State, list the property, sell it within 9 months, reimburse Medicaid for all benefits received, and then become ineligible if the remaining balance is still disqualifying." New York uses an "assignment of proceeds." Oregon will even petition the court to appoint a conservator to sell the property and turn the proceeds over to the agency if the applicant is incapacitated and unrepresented or financially abused. Two States said home property is exempt with no qualifications, and one State has no restriction on transfer of assets so its procedure for nonexempt home equity does not matter.

The Intent to Return Rule

The only good news about the transfer of assets restrictions for Medicaid applicants and recipients is that the rules can usually be circumvented. Obviously, the law itself exempts many transfers such as those which occurred more than 2 years before application or benefited an exempt relative. The most important factor putting property outside the reach of eligibility and transfer of assets limitations, however, is the "intent to return" rule. According to HCFA and SSI policy, if an applicant or recipient expresses an uncontradictory intent to return home, the home shall remain exempt indefinitely. Unlike certain post-eligibility treatment of income rules and lien requirements, the probability of a recipient's actually returning home is not the issue and need not be medically verified. Subjective intent of the recipient, according to explicit HCFA policy clarifications, is what matters.[6]

We asked States how they handle the intent to return rule. This policy is very important, because it determines whether an institution-bound applicant's most valuable assets will be exempt or not. If recipients are allowed to claim intent to return with near impunity and a State has no estate recovery program for benefits correctly received, then these large assets go entirely unencumbered to heirs. We found that half the States accept recipients' subjective intent according to SSI and HCFA policy and half require objective verification from a medical doctor. We asked one State which requires verification if it knew its policy violated SSI rules, and the response was positive. Georgia said "this [intent to return] ruling places virtually all home equity in an exempt status." Wisconsin remarked that it is

---

[6] The sources for these statements are a HCFA Memorandum dated January 14, 1986, and Transmittal No. 13 of the SSI-POMS dated November 1985.

actually "compelled by Federal quality control to have a physician's statement in the case record."

Although the intent to return rule is the most important exemption from property and transfer of assets restrictions, there are many other techniques to achieve the same purpose. We asked States how they dealt with divorce, trusts, and nonsupport suits[7] when these actions are taken for the purpose of divestment to qualify for Medicaid. Twenty-four States said they would permit divorce; 17, trusts; and 12, nonsupport suits. Twenty-one States said they would not permit divorce; 28 did not allow trusts; and 30 ruled out nonsupport suits. The rest of the States did not know. Most States were very vague on what, if anything, they would do to discover or counteract techniques that they claim to disallow. A few, however, are quite active. Connecticut, for example, told us it "had a case recently where an employed working man divorced his wife when she got Parkinson's disease. He would not give her anything except the small coverage she was entitled to for free through his employment-related insurance. The State required that he give her half the house and alimony. We got her a sizeable alimony and he has to increase the insurance." Oregon has used conservators appointed by the court to relitigate divorce decrees, invade trusts, and partition property interests. It does this to protect the recipient's ownership rights, but also to secure the State's claim on the assets. California has a law which provides for the automatic division of community property for Medicaid eligibility purposes when one spouse enters long-term care. This eliminates the need to divorce in order to shelter the well spouse's share. Oregon recommends a similar procedure to people who inquire. "Why force the well spouse into poverty," it reasons. The HCFA objects to such property divisions and has placed these States on the "compliance list." The result is "spousal impoverishment."

---

[7] The term "nonsupport suits" refers to the strategy, used successfully in New York, whereby a well spouse at home files a legal action against an institutionalized Medicaid spouse for failure to support. The objective is to redirect income of the Medicaid spouse, which is supposed to be applied toward cost of care, to the well spouse, without sacrificing Medicaid eligibility of the institutionalized spouse.

State Staff Speak Out on Transfer of Assets Problems

During telephone follow-up on the questionnaire responses, State staff were very candid about the issues related to treatment of resources and transfer of assets.

Some typical comments from big and small States all around the country are:

- "Recoveries are going down because people are giving away their property leaving less and less in estates." (MT)

- "We recover from people who are not clever enough to transfer their property, and everyone else goes scot-free." (CA)

- "We frequently see deeds quitclaiming excluded property to sons or daughters days before death." (CA)

- "[Some] people...get a new doctor's statement every 6 months saying the recipient would be coming home just to keep the home exempt and the recipient on assistance." (MT)

- "People are starting to use a lot of fancy footwork to avoid losing the 'family fortune.' They ask three questions: how should the recipient spend the money; what does the family have to lose; and how can we get around the rules." (MD)

- "If an applicant or recipient is over assets, they can reduce their assets by buying any exempt or excluded asset and requalify for assistance.... Families buy vehicles and even diamond pendants to qualify [exclude] the assets. Personal property is excluded so it can be given away at any time." (MN)

- "Many, many, many attorneys call on a daily basis looking for 'loopholes.' There are lots of welfare specialists who help people avoid welfare resource limits." (MN)

- "People are actually planning for Medicaid more and more. They're looking for ways to get the Government to take care of them. Any eligibility worker would be tempted to game the system to get benefits for a relative. They are torn about what to do when they know of a loophole and are talking to people with a serious problem.... The people we collect from are the ones not planning ahead or not smart enough to figure how the

system works and take advantage of it. It's really unfair." (MT)

- "We have had a problem in the last few years with law firms specializing in how to avoid payments and still be eligibile for Medicaid. Couched in terms of recipients' rights, they go on radio and TV talk shows. They picked up on the Federal Government's policy on 'intent to return' where the house remains exempt if you only say you intend to return.... The lawyers put it in terms of 'how to avoid having Medicaid take everything you own.'" (NY)

- "More and more recent refugees from the middle class are ending up on Medicaid. Especially in States with medically needy programs. People are carefully shepherding their assets to bring them under the exclusions allowed. [They put disqualifying cash into a new exempt car or pay off a mortgage on an exempt home in order to qualify for Medicaid.] These are people who are used to dealing with accountants and attorneys. They are familiar with the intricacies of tax avoidance, and they put the same principles to work to get within resource limitations. Social workers in hospitals advise people how to qualify for Medicaid by getting rid of their property." (ND)

- "Property transferred prior to 2 years is exempt. Ridiculous! The State had a statutory 7-year limit, but was told it was unconstitutional. People should be required to take care of their foreseeable needs before they give property away. When you are older, foreseeable needs automatically include possible catastrophic medical costs. It's not right to shirk that responsibility and depend on assistance." (CT)

- "Financial abuse cases are becoming more and more common. The family members' major concern is 'how can we get their assets without giving anything to the nursing home or the Government?'" (MN)

- "Life estates go to remaindermen after death. Sky rockets go off when we see one of these, because an illegal transfer has almost surely occurred." (OR)

- "Property held in joint tenancy passes by survivorship without probate. Joint tenancy is being used as a sheltering tool and not just with spouses." (CA)

- "Once a recipient understands the implications of estate recovery, there will be no estate left to capture--they will legally dispose of their property. We get calls from attorneys representing recipients every day. Once

an attorney is involved, they inevitably blow us away. They always figure out a way to shelter the resources. We only recoup from the naive and uninformed. Congress has to decide if the intent of public assistance (Medicaid) is to pay for a person's medical care or shelter income for their kids' inheritance." (UT)

- "Attorneys are getting very innovative with trusts. They are constantly looking for language that will make trusts okay within Medicaid eligibility criteria." (NJ)

- "The big problem is that we have to follow the SSI regs, even though the SSI population is different from the aged nursing home population. SSI people, for the most part, have minimal or no work history, thus minimal opportunity to attain property and other assets, but that's not true of a lot of people who need nursing home care. Following the SSI regs virtually assures there will be nothing to recoup when the patient dies."[8] (UT)

- "SSI recipients would be less likely to have resources than our nursing home Medicaid population. The problem is, the latter ones are the ones with the attorneys...." (VT)

- "Disposal of assets prior to death is much more of a problem to us than estate [recovery] limitations." (MN)

- "The bar offers courses in teaching attorneys to rearrange assets so as to throw the cost of medical expenses onto the public. They blatantly advertise the concept. They promote that it is proper to manage an estate so as to make a person eligible for a public benefit. This is recommended and the preferred way to do business." (PA)

---

[8] We have data from the Supplemental Security Income program which show that only approximately 1 to 10 percent of aged SSI recipients own homes, depending on the State. This means very little in itself, because institutionalized recipients--who are eligible because of the excessive cost of their institutionalization--are the people most likely to have homes (and other assets) and to know (or have relatives who know) how to protect them. Data on home ownership within this sub-group are not available.

State Recommendations

We asked States to recommend any changes in Federal law, regulation, or practice which would enhance Medicaid estate recoveries. Eighteen States contributed five strong recommendations related to treatment of resources and transfer of assets. Two States suggested tightening up the "intent to return" rules "to prevent virtually all nursing home recipients from remaining eligible indefinitely despite home ownership." Four States wanted the "bona fide effort to sell" policy reinstated so people would not be forced to liquidate property hastily and wastefully to the benefit of neither the family nor the State. Six States said we should close the "loopholes" in transfer of assets rules such as the ability of an institutionalized spouse to give away property to a well spouse who can then give it to anyone, thereby protecting the property permanently from recovery to pay for the cost of care. Five States would like to see the transfer of assets look-back authority extended from 2 to 3-to-5 years. Seven States asked for restrictions on trusts which go beyond the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).[9]

Clearly, what happens to the property of applicants and recipients before they qualify for Medicaid is very important to the success or failure of estate recovery programs. Retention of property in a recipient's possession during eligibility is equally critical. The lien provisions in TEFRA were designed to help States achieve this latter purpose. We discuss liens after the following inset.

---

[9] Section 9506 of COBRA provided that maximum distributions allowable from trusts are to be counted toward Medicaid eligibility limits whether or not the distributions are actually made. (National Health Law Program, p. 247.) Some States believe this provision will not solve their problem with "Medicaid-qualifying trusts."

WHY PEOPLE WITH SIZEABLE ESTATES END UP ON MEDICAID

Medicaid is a means-tested public assistance program, i.e., welfare.[a] How do people who possess appreciable assets qualify? We can explain this phenomenon best with a hypothetical, but stereotypical, example.

John and Mary Smith were born in 1900 when life expectancy was 46 years for men and 48 years for women.[b] They married in 1920, began payments on a home, and started a family. Theirs was the American dream--happiness and prosperity--until the early 1980s. At age 80, with an actuarial life expectancy of 8 years remaining,[c] John was stricken by Alzheimer's Disease.[d] After a gradual onset, he began to require almost full-time care. Even with daily help from a home health aide and the children--in their late 50s themselves--the responsibility finally overwhelmed Mary. By 1985, the family concluded that nursing home institutionalization could no longer be postponed.[e]

Robert, the couple's first child and a successful tax attorney, did some research. He located several excellent long-term care facilities, but was alarmed to learn that they charge from $20,000 to $25,000 per year.[f] Dad could easily live several more years.[g] With Mom getting frailer every day, their combined care costs could consume the family's entire net worth (a $65,000 home owned free and clear and $35,000 in certificates of deposit) very rapidly.[h] But, wait a minute, the folks have had Medicare for 20 years. It does not cover everything, but surely it will ease the burden.

When Bob visited the local Social Security office, however, he learned that Medicare does not cover custodial long-term care.[i] He checked his parents' Medicare supplemental insurance policies and found that they were no help either.[j] Furthermore, the couple had not purchased a special nursing home insurance policy which would have covered custodial long-term care. They did not know they were unprotected,[k] and no one ever tried to market such a policy to them.[l]

As he began really to worry, Bob got some advice from a colleague who had been through the same wringer. "Talk to the people at the Department of Public Assistance about Medicaid," she said. It has its shortcomings,[m] but Medicaid can be a big help. Somewhat abashed, Bob arranged an appointment with a Medicaid "eligibility worker" (EW). He learned that John could have $1020 per month of income and still qualify for Medicaid.[n] This

presented no apparent problem, because John's only income was Social Security and interest on his and Mary's savings. The resource limit, however, was another matter. Although their home would be exempt because Mary continues to live there, John could retain only $1,800 in other assets. "Not much," said Bob. The EW explained, however, that John could keep another $1,500 if it were earmarked for burial costs or contained in a cash value life insurance policy. Bob observed that $3,300 was still a long way from $35,000. He described the situation his parents faced and explained that Mary, having little income of her own, would be genuinely impoverished when John's income was diverted to his cost of care under Medicaid rules.[o]

At this point, the EW asked who really owned the certificates of deposit. Bob explained that his parents held them jointly. For purposes of determining Medicaid eligibility, such funds are considered available in full to the applicant; but they are also considered fully available to the other spouse as well, the EW clarified. "Have your mother open a different account in her name only. Put your Dad in a nursing home for a couple months. Then come and see me and we will cut the paperwork."[p]

Relieved, but with his interest piqued, Bob decided to do a little legal research.[q] He learned that if the joint tenancy gambit had not worked, there were many, many others to try. He also found two important pieces of advice which he immediately acted upon. First, John should enter the nursing home of choice as a private-pay patient for several months before converting to Medicaid. He might have trouble getting in as a Medicaid recipient.[r] Second, John and Mary's home, exempt now because of Mary's residence, could become nonexempt if Mary died or needed institutionalization herself. The State might also recover the home's value from John and/or Mary's estate. The smart thing to do is transfer John's equity to Mary and then have Mary deed the whole property to the family. That legally puts the home out of the State's reach.[s]

"Heck of a way to run a railroad," Bob thought. "Had we known, we could have transferred all the assets when Dad first got sick and avoided these complications. Better yet, we could have helped the folks buy insurance to protect against the risk. All I know for sure--it's a darn good thing Dad's too sick to understand that he's spending the end of his life on welfare."

(The appendix contains documentation for this scenario.)

LIENS

Section 1917 (a) of the Social Security Act codifies TEFRA's lien provisions. The HCFA has published regulations on liens and recoveries at 42 CFR 433.36. Unlike the statutory provision on transfer of assets, which grants an authority and then restricts it, the provision on liens imposes a prohibition and then delineates exceptions.

> No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except--

The first exception allows States to encumber property, pursuant to a court judgment, for the recovery of benefits incorrectly paid. Liens placed after death or for fraud only are not as important for purposes of this study, because (1) they do not fall under the strict limitations for liens filed before death pursuant to benefits correctly paid and (2) they are not as important for preventing transfer of assets to assure availability of an estate. We found this aspect of the lien authority to be little used and the recovery potential only nominal when compared with the expense of administration and recovery.

The second exception applies to the real property of institutionalized individuals who must contribute most of their income toward their cost of care, i.e., the same nursing home population we encountered in the transfer of assets provision. A lien may be placed on the real property of such an individual prior to death to secure recovery of benefits correctly paid only if:

1. the State determines, subject to a hearing, that "he cannot reasonably be expected to be discharged from the medical institution and to return home," and

2. neither the spouse, minor or dependent child, nor a sibling with an equity interest and residency exceeding one year lawfully resides in the home.

Any such lien must "dissolve upon that individual's discharge from the medical institution and return home."

We asked States whether they used liens to secure property for estate recovery purposes; if so, how; and if not, whether State legislation would be necessary to authorize their use. Fifteen States said they use liens and 35 States said they do not. Of the 35 States which do not use liens, 26 said legislation would be required to begin using them; 5 said legislation would not be required; and 4 did not

know. Of the 15 States that use liens, 8 use them only after a recipient's death and 3 only in cases of fraud. Thus, only four States place liens prior to death to secure benefits correctly paid. These four, however, do not all utilize the special authority granted in the second exception above. New Hampshire has a crafty way to get around Federal lien restrictions. It does not place liens on the real property of living recipients who are "Medicaid only." It does use such liens, however, on all other cases financed by the State even if Medicaid is involved.[10] This has the effect of securing the property for Medicaid recovery also. Another State seemed unaware of Federal regulations and did not specify when liens could be used legally: "Our rule is when in doubt, file a lien." Thus, only two States (Alabama and Maryland) intentionally utilize the TEFRA authority to place liens prior to death to secure property for recovery of benefits correctly paid.

California uses liens in two specialized ways. Some other States have similar programs. California is in deadlock with HCFA over "judgment liens" which are the State's substitute for the "bona fide effort to sell" policy (see footnote No. 5). Judgment liens allow the rare individual who does not exempt the home by claiming an intent to return to receive assistance while disposing of the nonexempt property. Connecticut has a similar program called "voluntary mortgages." These techniques ameliorate a major problem for many elderly people who are asset rich and cash poor by permitting home equity conversion over a long enough period to allow due diligence and dignity. "Voluntary liens," on the other hand, are used only after a recipient's death. California allows the elderly son or daughter of a deceased recipient to remain in the home if they agree to a lien securing the property for recovery of the State's claim. To take the home immediately would be pointless, because the residents might become dependent on public assistance themselves. Oregon gives offspring and other relatives the same consideration, although without requiring a formal lien.

Problems With Liens

We did not have to ask the States why they fail to use the TEFRA lien authority more extensively. They volunteered comments like these:

---

[10] Only approximately one-third of Medicaid cases in New Hampshire are also State supplemental cases and therefore covered by the lien provision. Furthermore, none of these are the high cost nursing home cases.

- "Liens are too difficult to administer because of Federal restrictions. Other property retention techniques, such as aggressive identification of assets, reversing illegal transfers, and challenging every possible resource shelter, are more effective under the circumstances." (OR)

- "Liens are very important, because they allow the State to keep track of property easily. Now it is too easy to lose property on the way to a probated estate. The property is transferred, reverts to a spouse, or the recipient goes off assistance and gets lost. But liens are too political. We cannot go to our legislature seeking lien authority. Citizens' associations accuse us of taking their life savings. It is very sensitive. But if the Federal Government said that to receive Medicaid, you must agree to a lien, we would participate." (MT)

- "The lien provision is impossible to administer. Effectively, TEFRA made liens impossible. Recipients transfer to spouse and spouse to child. The game is so easily played. We have a long active history in liens, but our eligibility people took a close look at the TEFRA lien rules and said 'not even remotely interested.'" (ND)

- "The lien provision isn't worth the powder to blow it to hell." (CT)

Several States told us that they used to have strong lien laws and other legal mechanisms to assure personal responsibility by people with means. We know that such programs were very common prior to the establishment of Medicaid. Today, however, few States have strong statutes on public assistance liens even for State-only programs. Some exceptions are Alabama, which may require an individual eligible for benefits (because of a temporary property or resource exclusion) to grant the agency a lien on the property, and Utah, which makes receipt of medical assistance, in itself, a lien on the recipient's estate. Likewise, Ohio law says "to the maximum extent permitted by Federal law and regulations, medical assistance is a lien and shall remain a lien until satisfied." New Hampshire's policy manual says "the client and his spouse, if any, must as a condition of eligibility acknowledge reimbursement and agree to the imposition of a lien before assistance can be granted." Missouri may propose legislation soon to permit a "quasi-lien" or claim on real estate held in joint tenancy. It is important to note that States which do have lien laws do not necessarily enforce them. At the other end of the spectrum are States like Texas, whose homestead law precludes the filing of liens

against homes, and Colorado, which interprets a State constitutional prohibition on making old age pensions conditional upon a promise to repay as forbidding Medicaid liens and estate recoveries.

The main objections to liens expressed by States were political sensitivity, TEFRA "loopholes," administrative difficulties and expense, and the possibility that liens would discourage the elderly from seeking care. On the other side of the ledger are Alabama and Maryland's experience. Alabama said, "Public acceptance has been very good. We see some irate people, but not many. Most people appreciate what the State contributes for their elder's care. They are willing to accept the [elder's] obligation to repay up to the elder's equity." Maryland said, "Advocacy groups for the elderly support the lien program and enabled its passage." Both Alabama and Maryland indicated their lien programs were not excessively difficult to administer. As to whether liens and estate recoveries discourage the elderly from seeking care, Oregon said it is a question of "pay me now, or pay me later." By the time people are so desperate that they seek Medicaid, their only other option is to sell their home immediately to pay for care. Many people are grateful for the opportunity to receive long-term care at Medicaid rates and repay the State after their own death and when the residence is no longer needed by dependents.

Perhaps the most important reason for the unpopularity of liens, however, is the authorizing legislation itself. The TEFRA proscribed the States from placing a lien unless an individual is permanently institutionalized and the home is unoccupied by specified dependent relatives. Those exclusions cover much of the real property of the elderly. What remains would presumably be countable toward eligibility limits, and hence usually disqualifying anyway, on the principle that a permanently institutionalized recipient with no qualifying dependents can hardly "intend to return" home. Thus, the population covered by the lien statute is very nearly a null set.[11]

---

[11] The proscription on liens is strongly enforced sometimes. Connecticut used to require people with term life insurance policies (i.e., no cash value, so not disqualifying) to make the State partial beneficiary of the policy. That way, if the recipient died, his nursing home costs would be reimbursed. The HCFA stopped this practice saying the State may not encumber a recipient's assets. Now, "Someone receives the benefits from the policy who did not contribute to the cost of care. They enrich themselves from Medicaid recipients at the expense of the taxpayers."

Alternatives to Liens

In the absence of a strong lien program to retain property in recipients' possession during their period of Medicaid eligibility, States must either employ alternatives or allow the techniques discussed in the transfer of assets section of this report to erode the estate. It is very much to the advantage of a recipient's family and frequently recommended in the legal literature, for example, to transfer even exempt property from a recipient to a spouse and thence to an adult child or other third party. This procedure prevents the property from becoming nonexempt if the well spouse dies, and it places the property permanently beyond the reach of estate recovery.

The State of Oregon compensates for the ineffectuality of liens by taking a strong legal stance on behalf of the recipient and the State. We have explained above how Oregon, pursuant to State statute, has conservators appointed to protect the property rights of recipients, files suits to reverse illegal transfers, relitigates abusive divorce decrees, partitions undivided property and invades trusts. These techniques, although they do not combat the statutory interspousal transfer "loophole" discussed above, help the State in other ways to retain property in the name of the recipient from whose estate it may legally be recovered to reimburse, in whole or in part, the cost of the long-term care. In combination with strong property ownership identification techniques and the chilling effect of strong enforcement on concealment and evasion, Oregon believes that it retains property in recipient estates as well as can be done under current Federal law.

To find out if other States use similar techniques, we asked about the use of guardianships or other legal action to contest property settlements, trusts or inappropriate transfers. We found that 12 States do so intervene, at least occasionally, and 38 do not. None, however, is as active or effective in these endeavors as Oregon. Pennsylvania actually told us that the responsibility of a guardian is quite the opposite, i.e., to preserve the property for the heirs: "There is a general feeling that if someone has to be hurt, let it be the State, especially when there are prospective heirs involved. There is no law in the State which makes repayment of assets to the State a high priority."

State Recommendations

Of the 11 major recommendations made by States in response to our inquiry, none was more frequently and strongly made than the one on liens. Nine states recommended loosening Federal restrictions on the placement of liens for the

purpose of securing property to be recovered from estates to repay Medicaid benefits correctly paid. Specifically, they said liens should bind a State's claim on a recipient's temporarily exempt property (1) if there is a spouse or dependent child, so that the asset can be recovered when they no longer need it, (2) during the lifetime of a surviving spouse or dependent child if the recipient predeceases them, (3) if a recipient returns home and goes off Medicaid if benefits were paid, (4) if the property is excluded because it produces income or for any other reason and (5) if the property is jointly owned to prevent its inuring without an estate to a joint tenant. Typical are the recommendations of New Jersey and North Dakota:

- "Federal law should allow the filing of an unconditional lien at the time of application for all Medicaid recipients." (NJ)

- "Make the lien a condition of eligibility and have it attach to the property, not the individual or estate." (ND)

If any property remains in a Medicaid long-term care recipient's legal possession after death, States have the option, subject to specified restrictions, to recover from the estate. Only having examined the difficulties with transfer of assets and liens, however, can we appraise the effectiveness and potential of Medicaid estate recoveries. States cannot recover what is not there.

ESTATE RECOVERIES

Section 1917 (b) of the Social Security Act codifies TEFRA's estate recovery provisions. The HCFA has published regulations on liens and recoveries at 42 CFR 433.36. Like the provision on liens, the statutory provision on recoveries begins with a prohibition which is then qualified by exceptions:

> No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except--

The first exception allows recovery from the same nursing home population we encountered before in the sections on transfer of assets and liens. They are the people who are required to contribute most of their income toward their cost of care. Recoveries may be made from their estates or upon sale of a property subject to a lien.

The second exception permits recovery from the estate of "any other individual who was 65 years of age or older when he received such assistance."

The recovery authority granted in these two exceptions is circumscribed by the following provisos. Any recovery based on either exception may be made only after the death of any surviving spouse and when there is no surviving minor or disabled child. A recovery based on a lien may be made only when (1) no sibling with residency of at least a year nor (2) any son or daughter with residency of at least two years who provided care which postponed institutionalization is lawfully residing in the home and has been since the date of institutionalization.

As we know, this convoluted statutory provision delimiting recovery from liens is very nearly moot, because all but two States eschew liens for this, as well as the aforementioned, reasons. The provisions permitting recovery from the estates of individuals who are over the age of 65 or institutionalized, however, are fairly widely used. We turn now to the application by States of this authority.

State Performance

As noted earlier, all States and the District of Columbia responded to our questionnaire. Dropping Arizona, which has no Medicaid long-term care program, leaves 50 respondents which might have estate recovery programs. Of these, 17 recover benefits correctly paid and were able to give us data on both the amount of recoveries and the cost of recovery.[12] Seven other States recover benefits correctly paid but could not provide data on the amount of recoveries (two States) or the cost of recovery (five States). Twelve States recover incorrect benefit payments only. Few of these were able to provide data on either the amount or the cost of recoveries. Seven States have no estate recovery program, but have at least considered starting one. Seven other States have no program and no plans for one. (See the chart on the following page.)

---

[12] Alabama does not do estate recoveries for correct benefits routinely. Because the State's lien program achieves basically the same purpose, however, Alabama is included.

MEDICAID ESTATE RECOVERY PROGRAMS

BY TYPE OF PROGRAM

G = General Recovery States = 24

I = Recover Only Incorrect Benefits = 12

N = No Estate Recoveries = 14

The 16 States and the District of Columbia which recover benefits correctly paid and reported dollar figures for the amount and costs of recoveries:

- employ 62.95 full time equivalent (FTE) staff in the function,
- at a cost of $2,005,396 (or $31,857 per FTE),
- to recover $28,919,560 or
- $14.42 for every $1 spent on recovery. (See tables 1 and 2)

These same States reported only $8,065,878 in "probate recoveries" to HCFA in 1986. California, which reported $12 million to us for estate recoveries and only $71,486 to HCFA, accounts for most of the discrepancy. Massachusetts reported $4.8 million to us and none to HCFA. The same is true for several other States. Various factors account for these discrepancies. There are "nonprobate" estate recoveries, recoveries reported unspecifically to HCFA as "third party liability," and some State-only recoveries mixed in with the figures reported to us. These items should not account for more than a fraction of the differential however. The States are required by law to return the Federal share of Medicaid estate recoveries to the United States Government. Sometimes, however, the amount of the Federal share may not be clear. For example, some State programs are funded with only State money. States may reimburse these programs first before returning any money to the Federal Government for combined Federal/State programs. After the State-only costs of a deceased recipient are paid, there may be little or nothing left in the estate to reimburse for Medicaid (i.e., Federal/State costs). States are reputed to be adept at minimizing the Federal share of recoveries with this and many other tactics. A thorough audit of the function is needed to determine whether the Federal Government is getting its full share of the proceeds.

TABLE 1

ACTIVE MEDICAID ESTATE RECOVERY PROGRAMS
ANNUAL RECOVERIES, COSTS, AND MEDICAID PROGRAM DATA[1]

State	Estate Recoveries	Cost of Recovery	FTEs	Cost Per FTE	Nurs.Home[2] Recipients	Nurs.Home[2] Expenditures ($ Millions)	Recipients Over Age 65	Payments for Over Age 65 Recipients ($ Millions)	Total Recipients	Total Vendor Payments ($ Millions)
AL	202,000	$ 55,000	1.8	$30,556	20,741	$ 133.9	84,688	$ 148.2	316,159	$ 375.4
CA	12,000,000	625,600	17.0	36,800	131,340	880.8	456,940	909.1	3,380,660	4,045.3
CT	2,100,000	250,000	11.0	22,727	31,086	274.5	35,491	296.5	217,442	594.9
DC	300,000	129,408	4.0	32,352	3,145	61.7	9,737	92.1	98,277	297.7
HI	68,208	8,280	.5	16,560	4,064	59.6	11,259	60.3	92,238	140.4
IL	1,620,000	70,400	2.0	35,200	73,367	453.3	75,958	333.6	1,063,367	1,652.9
MA	4,800,000	93,450	4.0	23,363	44,017	429.8	104,746	621.4	522,948	1,432.6
MD	1,230,071	104,000	2.5	41,600	26,795	195.1	42,903	227.6	328,809	583.9
MO	453,000	21,391	1.0	21,391	29,169	209.9	63,763	225.0	355,974	524.9
MT	150,000	15,000	.5	30,000	5,012	41.0	6,412	38.6	47,321	95.5
ND	316,955	34,200	1.0	34,200	6,123	49.8	8,901	55.3	36,674	116.7
NH	900,000	66,000	3.0	22,000	5,621	58.7	9,418	63.2	37,698	118.0
NJ	435,000	150,000	3.4	44,118	32,203	333.0	63,493	413.2	581,433	1,144.7
OR	4,000,000	306,000	9.0	34,000	12,216	76.2	20,018	80.7	152,502	238.7
RI	45,000	26,000	1.0	26,000	10,619	91.0	20,521	117.9	100,750	250.0
UT	230,000	45,000	1.0	45,000	5,645	30.0	7,739	27.9	72,210	109.7
VT	69,326	5,667	.3	22,668	3,409	30.0	7,213	33.6	50,385	89.4
Sub-Total	28,919,560	2,005,396	62.95	$31,857	444,572	$ 3,408.3	1,029,200	$ 3,744.2	7,454,847	$11,810.7
FL[3]	640,941	UNK	UNK	UNK	37,710	$ 353.4	112,652	$ 413.9	561,943	$ 943.1
GA[3]	1,089,358	UNK	UNK	UNK	35,897	214.6	91,843	246.8	468,887	759.6
IN[4]	400,000	UNK	UNK	UNK	40,561	328.9	41,332	271.5	283,956	746.7
MN[3]	4,722,895	UNK	UNK	UNK	46,852	446.2	55,773	434.1	357,260	1,001.1
NY[3]	5,942,995	UNK	UNK	UNK	110,433	2,096.7	341,784	3,782.1	2,242,140	7,588.0
Sub-Total	12,796,189	UNK	UNK	UNK	271,453	$ 3,439.8	643,384	$ 5,148.4	3,914,186	$11,038.5
Tot. ARS[5]	41,715,749	UNK	UNK	UNK	716,025	$ 6,848.1	1,672,584	$ 8,892.6	11,369,033	$22,849.2
Oth. St.[6]	-0-	N/A	N/A	N/A	659,547	$ 4,750.3	1,387,390	$ 5,203.2	8,850,837	$14,515.2
Gr. Tot.[7]	41,715,749	UNK	UNK	UNK	1,375,572	$11,598.4	3,059,974	$14,095.8	20,219,870	$37,364.4

[1] Medicaid program data come from official HCFA-2082 data for Federal FY 1985. Source: Office of the Actuary, Division of Medicaid Cost Estimates.

[2] Excludes ICF/MRs; includes SNF and ICF Other.

[3] Amounts listed as estate recoveries are those reported to HCFA as "probate recoveries" in Federal FY 1985.

[4] Indiana no longer tracks estate recoveries. This figure is a projection based on past recovery performance.

[5] ARS: Active Recovery States.

[6] A few other States report "probate recoveries" to HCFA but these are only for benefits incorrectly received.

[7] Excludes the territories and Arizona.

To estimate the total current value of Medicaid estate recoveries nationally, we started with the figures reported to us. These figures should be the most accurate, because they come directly from program staff. For States which did not report a recovery figure to us, either because they are county administered or because their recoveries are handled by a contractor, we used the figure they reported to HCFA for "probate recoveries" or, as in one case, a best estimate based on past recoveries. Two States which claimed to do general estate recoveries were unable to report a dollar figure to us, reported none to HCFA, and were not very active programmatically. Dropping them from the analysis gives us a conservative estimate of $41,716,000 for Medicaid estate recoveries nationally based on benefits correctly paid. Some small portion of this may include recoveries of benefits incorrectly paid, but we found such recoveries to be nominal at best in most States.

Although our questionnaire did not ask why 26 States fail to recover from estates for benefits correctly received, two States volunteered these comments:

> "We have not pursued estate recoveries because we do not think it is worth it. Very few people in nursing homes have estates." (SC)
>
> "We just do not see estate recoveries as worthwhile to pursue. Too costly administratively." (WV)

Telephone follow-up elicited similar comments from other States. Based on the experience of active estate recovery programs recounted below, however, we conclude that Medicaid recipients in nursing homes frequently do have estates, sometimes large ones. We may also say with confidence that recovery from these estates is very cost-effective. It is true, however, that actual effectiveness levels vary widely among States.

Estate Recovery Effectiveness Ratios

To compare the effectiveness of the 22 active recovery States, we computed 7 achievement ratios. State scores on each of these ratios are shown in table 2. We assigned a rank to each State based on its average rank on the seven ratios. This allowed us to array all 22 active recovery States based on their overall success with the program. Some interesting comparisons emerge.

On the "recovery ratio," i.e., dollars recovered per dollar spent, the range was from $1.73 in Rhode Island to $51.36 in Massachusetts. Oregon's recovery ratio was only $13.07 to $1, sixth in rank, and below the mean. But Oregon ranked

first on all six of the other ratios. This is not difficult to understand if we look at the marginal utility of a State's dollar investment in recoveries. For example, Massachusetts, with a recovery ratio four times Oregon's, recovers less than one-fourth as much as Oregon overall per elderly Medicaid recipient. Presumably, Massachusetts could add staff, recover much more, and still maintain a satisfactory recovery ratio. The bottom line, therefore, is not the recovery ratio, but the total amount cost-effectively returned to Medicaid to meet the needs of other recipients.

Several different ratios are necessary to rank States fairly, because of wide variations among States in the percentage of recipients who are over age 65 and in the percentage of vendor payments for people over 65. Recipients over age 65 range from 7 percent in Illinois to 28 percent in Texas, with a mean of 15 percent. Vendor payments for recipients over age 65 vary from 20 percent in Illinois to 54 percent in New Hampshire, with a mean of 38 percent. These variations skew the individual effectiveness ratios. For example, New Hampshire, with nearly double the percentage of recipients over age 65 (25 percent) of Oregon (13 percent), has very low ratios based on recipient age even though its ratio based on total recipients is quite close to Oregon's. A composite of different effectiveness measures tends to average out these discrepancies in caseload characteristics.[13] To obtain an overall ranking of effectiveness in estate recovery, we assigned a score in each ratio equal to each State's rank. Then we summed the scores and ranked the averages. That gave a list of active recovery States by level of effectiveness.

---

[13] We did not weight the effectiveness ratios because we had no basis or rationale to do so.

TABLE 2

MEDICAID ESTATE RECOVERY PROGRAMS
EFFECTIVENESS MEASURES

	1 Recovery		2 Nurs. Home Recipient		3 Nurs. Home Payment		4 Over 65 Recipient		5 Over 65 Payment		6 Total Recipient		7 Total Payment		Total Score (Sum of Ranks)	Overall Rank
State	Ratio	Rank	Ratio	Rank	Ratio	Rank	Ratio	Rank	Ratio	Rank	Ratio	Rank	Ratio	Rank		
AL	3.67	14	9.74	21	.2	15	2.39	21	.1	18	.64	21	.1	11	121	19
CA	19.18	4	91.37	6	1.4	3	26.26	10	1.3	3	3.55	8	.3	5	39	5
CT	8.40	11	67.55	7	.8	6	59.17	4	.7	7	9.66	4	.4	4	43	6
DC	2.32	16	95.39	5	.5	10	30.81	7	.3	13	3.05	11	.1	12	74	10
HI	8.24	12	16.78	17	.1	19	6.06	19	.1	19	.74	20	.0	20	126	20
IL	23.01	2	22.08	14	.4	12	21.33	12	.5	9	1.52	14	.1	15	78	12
MA	51.36	1	109.05	3	1.1	4	45.83	5	.8	5	9.18	5	.3	6	29	4
MD	11.83	8	45.91	10	.6	8	28.67	9	.5	10	3.74	7	.2	8	60	8
MO	21.18	3	15.53	18	.2	17	7.10	17	.2	15	1.27	17	.1	17	104	16
MT	10.00	9	29.93	13	.4	13	23.39	11	.4	12	3.17	10	.2	9	77	11
ND	9.27	10	51.76	9	.6	9	35.61	6	.6	8	8.64	6	.3	7	55	7
NH	13.64	5	160.11	2	1.5	2	95.56	2	1.4	2	23.87	2	.8	2	17	2
NJ	2.90	15	13.51	19	.1	21	6.85	18	.1	21	.75	19	.0	21	134	21
OR	13.07	6	327.44	1	5.2	1	199.82	1	5.0	1	26.23	1	1.7	1	12	1
RI	1.73	17	4.24	22	.0	22	2.19	22	.0	22	.45	22	.0	22	149	22
UT	5.11	13	40.74	11	.8	7	29.72	8	.8	6	3.19	9	.2	10	64	9
VT	12.23	7	20.34	15	.2	18	9.61	16	.2	17	1.38	16	.1	19	108	17
Mean	14.42	NA	65.05	NA	.8	NA	28.10	NA	.8	NA	3.88	NA	.2	NA	NA	NA
FL[8]	14.42	5	16.99	16	.2	16	5.69	20	.2	14	1.14	18	.1	13	102	15
GA[8]	14.42	5	30.35	12	.5	11	11.86	14	.4	11	2.32	13	.1	14	80	13
IN[8]	14.42	5	9.86	20	.1	20	9.67	15	.1	20	1.41	15	.1	16	111	18
MN[8]	14.42	5	100.80	4	1.1	5	84.68	3	1.1	4	13.22	3	.5	3	27	3
NY[8]	14.42	5	53.82	8	.3	14	17.38	13	.2	16	2.65	12	.1	18	86	14
Mean	14.42	NA	47.14	NA	.4	NA	19.89	NA	.2	NA	3.27	NA	.1	NA	NA	NA
ARS[9] Mean	14.42	NA	58.26	NA	.6	NA	24.94	NA	.5	NA	3.67	NA	.2	NA	NA	NA

[1] Recovery Ratio = Recoveries/Cost of Recovery

[2] Nursing Home Recipient Ratio = Recoveries/Nursing Home Recipients (i.e., SNF + ICF Other)

[3] Nursing Home Payment Ratio = Recoveries/Nursing Home Payments (i.e., SNF + ICF Other Payments)

[4] Over 65 Recipient Ratio = Recoveries/Recipients Over Age 65

[5] Over 65 Payment Ratio = Recoveries/Payments for Over Age 65 Recipients

[6] Total Recipient Ratio = Recoveries/Total Recipients

[7] Total Payment Ratio = Recoveries/Total Payments

[8] Cost of recovery data unavailable for these States. Impute the mean of the other States $14.42/$1 and a rank of 5.

[9] ARS: Active Recovery States

States by Overall Rank	
1	OR
2	NH
3	MN
4	MA
5	CA
6	CT
7	ND
8	MD
9	UT
10	DC
11	MT
12	IL
13	GA
14	NY
15	FL
16	MO
17	VT
18	IN
19	AL
20	HI
21	NJ
22	RI

National Projections

Because States vary widely in estate recovery effectiveness, from nonparticipation to recovery of 1.7 percent of total vendor payments, it is reasonable to ask what the national recovery potential would be based on various levels of effectiveness. To compute such estimates, we multiplied the various effectiveness ratios by national totals and then averaged across all of the ratios. We did this for the ratios of the most effective State (Oregon), for a successful large State (California),[14] and for the mean of all the ratios. The result was that if every State in the country recovered from estates with the same level of effectiveness as Oregon, then the national potential would be $589 million; if at the level of California, then $123 million; and if at the level of the mean of current active recovery States, then $74 million.

TABLE 3

ANNUAL MEDICAID ESTATE RECOVERIES*
(National Projections in $ Millions)

State	Nursing Home Recipient		Nursing Home Payment		Over 65 Recipient		Over 65 Payment		Total Recipient		Total Payment		Average in $ Millions
	Ratio	Proj.	Ratio	Proj.	Ratio	Proj.	Ratio	Proj.	Ratio	Proj.	Ratio	Proj.	
Oregon	327.44	$450.4	5.2	$603.1	199.82	$611.4	5.0	$705.0	26.23	$530.4	1.7	$635.0	$589.2
Mean	58.26	80.1	.6	69.6	24.94	76.3	.5	70.0	3.67	74.2	.2	75.0	74.2
California	91.37	$125.7	1.4	$162.4	26.26	$ 80.4	1.3	$183.0	3.55	$ 71.8	.3	$112.0	$122.6

*The projections are based on the ratios times national totals less the territories and Arizona. Factors for each ratio are then summed and averaged to give the national projection in the last column. For example: Oregon recovers 5% of its Medicaid payments to people over age 65 from estates. If 5% of such payments were recovered nationally, total recoveries would be $705.0 million. Based on Oregon's recovery of $327.44 per nursing home recipient, national recoveries would be $450.4 million. Adding all the projections for each of the ratios and averaging gives us a national projection of $589.2 million based on Oregon's level of effectiveness.

---

[14] California shot up from $2 million in estate recoveries for 1983 to $12 million projected for 1987. We believe that estate recoveries may continue to rise in California. Program staff were not so confident, however, for reasons discussed in this paper.

We believe these projections are very conservative considering that the current recovery levels on which they are based have been achieved without any technical assistance and with very little emphasis on estate recoveries either nationally or within the States. It is also important to note that these projections are realistically achievable under current law, which has been shown above to be very disfavorable to estate recoveries. State staff who were asked the question estimated that Medicaid estate recoveries could be increased by a factor of from three to five times by eliminating statutory "loopholes" in transfer of assets, liens, and recoveries. For reasons we will discuss in the conclusion, these estimates could be far below the true potential. (See the chart on the following page.)

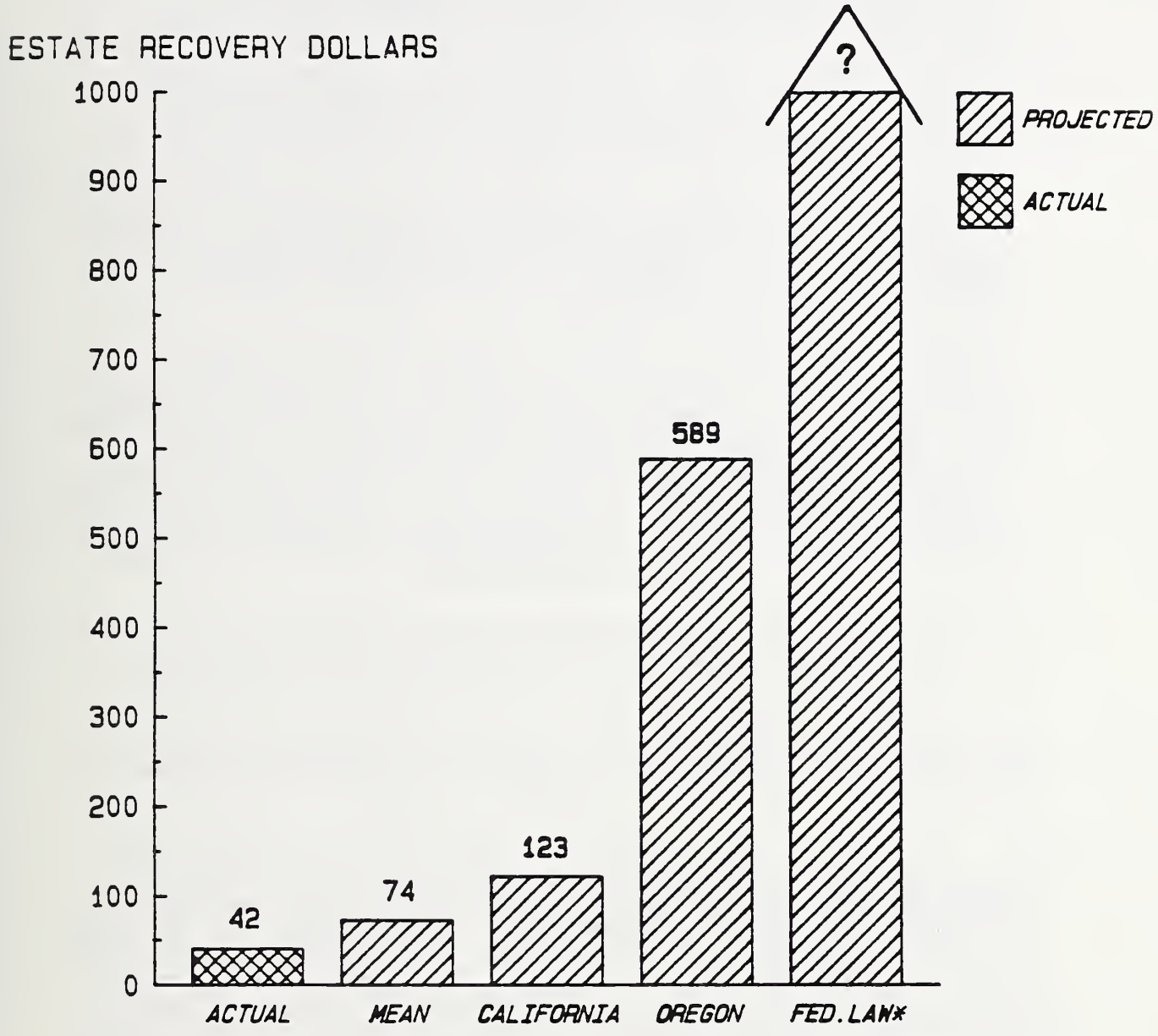
Several States discerned an interesting relationship between estate recovery potential and Medicaid eligibility policy. For example, HCFA recently compelled Alabama to accept a recipient's stated "intent to return" to a home as sufficient cause to exempt the home instead of requiring a doctor's certification. Consequently, many more homes will be exempted and the State's lien recoveries will go up. Minnesota, on the other hand, used to have very liberal Medicaid eligibility policies. As they have become increasingly restrictive, however, more and more people have had to liquidate their property before becoming eligible. As a consequence, less property remains in recipients' possession to be recovered from their estates. The question becomes whether the public is better served by strict eligibility policies which leave little property to recover from estates or liberal eligibility followed by recovery of benefits after death. An important consideration, according to Minnesota, is that people rendered ineligible by strict eligibility policies tend to consult attorneys, find "loopholes" and end up on Medicaid anyway.

Of the 12 States which reported they recover only incorrectly paid benefits, only 4 provided recovery amounts. The others said recoveries were nominal, minimal or they did not know. Recoveries reported ranged from $3,600 in Louisiana to $400,000 in Pennsylvania, with recovery ratios between $3.21 to $1 and $1.24 to $1 respectively. Based on this information, we decided to drop incorrect benefit recoveries from this analysis. Although fraud recoveries and policy enforcement are important, they are not a large nontax revenue source for Medicaid like general estate recoveries.

Organization and Procedures

Among the 24 States with any general estate recovery involvement, we found a wide range of organizational

MEDICAID ESTATE RECOVERIES
Actual and Potential for United States
($ Millions)



*UNKNOWN HOW MUCH COULD BE RECOVERED FROM RECIPIENT ESTATES IF FEDERAL LAWS ON TRANSFER OF ASSETS/LIENS/ESTATE RECOVERIES WERE STRENGTHENED

awareness and sophistication. One State's third party liability (TPL) director did not even know his State recovered from estates. At the other end of the spectrum, States like Oregon, California and Connecticut have highly organized programs with skilled personnel in central units.[15] General estate recovery programs break down into four organizational categories. Six States have central estate recovery units--usually part of a broader recovery, collection or TPL division--which employ experts dedicated exclusively to estate recoveries. Five States have estate recovery specialists in their central offices who work basically alone, but with clerical and legal assistance as needed. Four States merely share the responsibility for estate recoveries among general TPL or collections staff. Finally, nine States have no real centralized responsibility for estate recoveries. They depend on eligibility workers in the field referring cases to legal services divisions, often at the county level. Of the 10 most effective recovery States, 9 have central units or specialists dedicated to estate recoveries.

We asked the general recovery States about a series of procedures and techniques in an attempt to determine what works best. For example, we asked what procedures, if any, they had to trigger an estate recovery effort when a recipient or spouse dies. Of the 24 States with general estate recovery programs, only 18 had such a procedure. The six which did not were, unsurprisingly, among the second half tier of States by order of estate recovery effectiveness. The most common procedures used were:

1. Eligibility workers report deaths of recipients over 65 including (sometimes) assets and other information (seven States).

2. Estate recovery staff research legal notices, court records, vital statistics or other public information

---

[15] Centralized and specialized estate recovery units are very important, several States pointed out, because of the technical expertise needed to recover from estates. Eligibility workers have neither the knowledge nor the time to pursue recoveries. Estate specialists need to know the law, real estate principles and skip tracing as well as every nuance of Medicaid eligibility and resource policy related to estates. With a central unit to which they can refer difficult property cases, eligibility workers are less likely to ignore problems they do not understand.

sources (six States, one of which had a computer match with vital statistics).

3. Computer generates a list of deaths of recipients over age 65 (four States; one other is planning such a system).

4. Personal representative or family member is required to notify the State when filing for probate (three States).

5. Nursing homes report recipient deaths (two States).

6. Probate court or registrar of wills reports probates (two States).

The more sophisticated procedures may not be much more effective than the simple process of having eligibility workers report the deaths of recipients who possess assets. To delay until someone else reports a death or until an estate is filed, says Oregon, is like "waiting for the gun to go bang before you duck." You are too late to protect the State's claim. Also, the State may not need to know everyone who died or generated a probate. The State may only need to know who died with a recoverable estate. Some States recover, however, not only from recipients who die while on assistance, but also from past recipients and/or spouses predeceased by recipients. These States need to match all probates against their lists of current and past recipients and surviving spouses.

We asked how many of the 22 active estate recovery States attempt to track people who go off assistance in order to recover from their estates when they die. Fifteen do. Of the 10 most effective estate recovery programs, only California and Washington, D.C. do not track ex-recipients for estate recovery. Presumably, a long-term care recipient in these jurisdictions could drop from Medicaid just before death and avoid estate recovery.

Many Medicaid recipients die without wills (intestate). Some of these--only 1 or 2 percent in Oregon--die without heirs, devisees, or claimants. Unclaimed assets in such estates revert (escheat) to the State. States which have efficient Medicaid estate recovery programs will lay claim to assets in estates whether or not the recipient dies intestate. These States are required by law, as explained above, to return the Federal share of the proceeds to the United States Government. States which do not have efficient, general estate recovery programs (the majority) do not recover from estates whether the recipient dies intestate or not. In such States, any heirs, devisees or claimants may file for the

proceeds of an estate. If there are no claimants, then the proceeds escheat to the State. In either case, if the State does not have a fully effective estate recovery program, the Federal Government gets nothing.

Spousal Recoveries

We asked what, if anything, a State does about recovery when a Medicaid recipient dies in a nursing home, leaving an exempt spouse in an excluded home. Forty-four States, including 16 of the active recovery States, do nothing. Many said that Federal law does not permit recovery from surviving spouses or other exempt dependents, a dubious interpretation of the law:

> ...there does not appear to be any time limit on recovery. Thus, action could be suspended for a lengthy period after a recipient's death while a surviving spouse or child remains alive. (Deford, p. 137)

Several States explained that because there is no estate of the recipient (the property passed to the spouse with right of survivorship) and no liability of the spouse (who was never on assistance), there is no recourse of spousal recovery--"Catch 22".[16] Of the six States which do recover from spouses, two recover only if the property was solely owned by the recipient. This eliminates most spousal recoveries, because most assets are jointly held. Of the remaining 4 States, all of which are among the top 10 recovery programs, North Dakota and New Hampshire do some but not a lot of recoveries from spouses. Only Oregon (No.1) and Utah (No.9) actively track and consistently recover from spouses whenever possible. Note again that nothing stops a surviving resident spouse or other exempt dependent from transferring the property, which once belonged to a recipient, to a related or unrelated third party thereby removing it from a State's recovery authority altogether. Spousal recoveries, like estate recoveries in general, are usually made from people who are unaware, or not philosophically disposed, to take advantage of

---

[16] Connecticut used to put a "paper lien" on a spouse's property when the recipient dies just to hold the property until it could be recovered from the spouse's estate. The HCFA made them stop this practice. With no way to keep the property in the spouse's name or to know when the spouse dies or the property is transferred, Connecticut terminated spousal recoveries.

provisions in the law permitting them to shelter their property.

Other Practices

Several other conditions are important to successful estate recoveries. We asked how many States have a special standing in probate proceedings, i.e., the right to collect ahead of certain other claimants. Twenty states do and 30 do not. Of the 22 active estate recovery States, 15 have special probate standing and 7 do not. Of the 10 most effective estate recovery States, only Massachusetts and Washington, D.C. do not have special standing. Although there was some variation among States, the most common probate standing was similar to Maryland's: "The Medicaid agency is coequal with general creditors of the estate. Priority claims such as probate costs and fees, funeral expenses, litigation costs, and the costs relating to the last illness are eligible for payment prior to the claim of the Medicaid agency. However, claims of beneficiaries named in a will or heirs in intestacy, are subordinate to the agency's claim."

Based on an exemplary practice in Oregon which is authorized in State statute, we asked how many States attach bank and nursing home accounts automatically upon the death of a recipient. Seven States said they have procedures to attach. Of these, five attach only in the sense that assets in such accounts become part of the formal or informal estate distribution process. Another State attaches only if benefits have been incorrectly paid. Only Oregon routinely attaches bank and nursing home accounts expeditiously following all appropriate recipient deaths.

Accounts Receivable

Sometimes, when an estate is probated, claimants have the choice whether to accept a contract, note, or physical property, or to permit the estate to be liquidated and accept cash. Liquidation often means loss of value as when contracts are sold at a "discount" or hard assets are auctioned. We asked how many States accept installment payments and/or hard assets in compensation of their claims so that they have to deal with accounts receivable and property management.[17]

---

[17] Property management can be a nuisance. Oregon has approximately $150,000 worth of personal property which has accumulated in a safe deposit box since the last auction seven years ago. The State has received mobile homes, automobiles, farm equipment, furniture, rings, watches and even a gold mine in compensation for its claims. Estate recovery staff have not used a Government pen since receiving $5,000

Most States said they require liquidation within the estate--they are not in the loan or real estate business. Four States, however, reported accounts receivable. Only 1 of these, Oregon, was among the top 10 recovery States. Oregon has over $5 million in accounts receivable, which generate an average of $85,000 per month in revenue for the State's Medicaid program.[18] Alabama, Missouri and Montana also have accounts receivable, but they average only $36,000 per State.

Oregon's accounts receivable program, although highly profitable for the State, is also intended to help families keep homes they would otherwise have to lose in order to satisfy claims on a loved one's estate. Often a family member moves in or the home becomes a rental and the proceeds go to pay the State's claim until the family owns the house free and clear again. Thus, the elder is able to use home equity for cost of care while the family retains the home in the end. This is an example of the elusive "home equity conversion" applauded in the long-term care funding literature, but with a public sector assist. If the same program were available during recipients' lifetimes, it would be even more beneficial. In essence, home equity conversion is what would happen if Medicaid were available to anyone with a catastrophic long-term care need, conditional upon a lien on their property recoverable after their deaths and after the deaths or seniorities of their dependents.

Exemplary Practices

We asked States to tell us what they consider their most exemplary estate recovery practices. Thirteen states responded with 22 practices. The most common exemplary practices related to reporting deaths or estate filings and then matching this information to Medicaid eligibility records. These included manual and automated systems to obtain information on deaths and estates from local welfare offices, probate courts, vital statistics agencies, nursing homes, and newspaper clipping services. One such practice stands out. Connecticut requires that anyone filing an application for administration of a decedent's estate in

---

worth of advertising/promotional pens from one recipient's estate.

[18] For purposes of analysis and comparison with the other States, Oregon's total Medicaid vendor payments for Federal Fiscal Year 1985 were $238,650,352; payments for recipients over age 65 were $80,665,357. The State had 152,502 recipients in 1985, of whom 20,018 were over 65.

probate court must declare if the deceased or any of his or her family ever received public assistance. If so, the probate court notifies the State and the State files a claim. Six States mentioned practices related to legal enforcement of a State's claim. These included the general need for strong legal support, lien filing, getting the State appointed administrator of small estates in the absence of anyone else, using conservatorships to get assets returned to recipients, attaching financial accounts, attacking shelters, and using open-ended mortgages. Illinois and Oregon mentioned the importance of a central estate recovery unit which frees local offices to concentrate on eligibility and less complicated legal issues. California cited its practice of recovering Medicare Part B buy-in premiums paid by the State as well as Medicaid vendor payments.[19] (See table 4.)

State Statutes

To find out about the importance of State statutes for Medicaid estate recovery programs, we asked three questions: which statutes authorize estate recoveries; which restrict them; and what legislative initiatives are planned or pending. We found there is not always a strong relationship between the laws and the practices of estate recoveries. For example, the District of Columbia, although planning some, has no authorizing statutes, regulations or policies, but collects from estates anyway. Virginia, on the other

---

[19] Oregon has an interesting arrangement with an heir finding service. Heir finders locate money, real property or other assets for which the owner or heir has not been found. They find the owner or heir and offer information on the windfall in exchange for a percentage. Sometimes the heir is a Medicaid recipient, in which case Medicaid has a claim which is like "picking money up off the street." This happens five or six times a year. Heir finders always check with Oregon's estate recovery program early in their search. If Medicaid has a claim, they need look no further.

Connecticut has a program, as most States probably do, whereby money left inactive in an account is escheated to the State after a certain period (7 years in CT). The estate recovery program checks the State-published list of such accounts and files a claim when it finds a recipient's name. It recently found $35,000 belonging to an incapacitated recipient. Given the prevalence of mentally debilitating diseases like Alzheimer's, lost financial accounts like these may be more common than is generally realized.

TABLE 4

MEDICAID ESTATE RECOVERY PROGRAMS
STATE CHARACTERISTICS
(See Coding Legend Opposite)

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
ST	PROG TYPE	VRFY ASST	IDEN PROP	DVRC	TRST	SUIT	INT/ RTRN	GUAR	PROC	STND	ATCH	TRCK	SPOU	LIEN	ACCNTS RECVBLE ($1000)
AL	G	X	X	X	X	X		X	X	X				Y	29
CA	G	X				X			X	X				YD	0
CT	G	X			X		X	X	X	X	X	X		YD	0
DC	G	X		DK	DK	DK			X					NU	0
HI	G	X	X	X	X	X								NN	0
IL	G								X	X	X	X	X	NL	0
MA	G			X	DK	DK	X		X			X	X	YD	0
MD	G						X		X	X	X	X		Y	0
MO	G	X				X	X		X	X		X		NL	25
MT	G	X	X	X	X	X	X	X	X					NL	55
ND	G			X	X	X	X	X	X	X	X	X	X	NN	0
NH	G	X		X		X	X			X		X	X	Y	0
NJ	G	X		X	X	X	X	X	X	X		X		YD	0
OR	G	X	X	X	X	X	X	X	X	X	X	X	X	NN	5,000
RI	G	X			X	X	X		X			X		YD	0
UT	G	X							X	X	X	X	X	YD	0
VT	G	X					X							NL	0
FL	GN	X	X	DK	DK	DK			X	X				NL	0
GA	GN	X		DK	DK	DK								Y	0
IN	GN	X					X	X	X	X		X		NN	0
MN	GN				X	X	X	X	X	X		X		NU	0
NY	GN	X	X	X	X		X			X		X		YD	0
TN	GN			X	X	X				X				YD	0
VA	GN	X	X	X		DK	X			X				NL	0
IA	I				X	X				X				NL	0
KS	I	X			X	X								NL	0
LA	I	X	X	X	X									NL	0
MI	I									X				YF	0
MS	I	X	X	X	X	X			X		X			NL	0
NB	I	X	X	X	X	X	X							NL	0
NC	I	X	X	X	X	X	X	X						NL	0
OK	I	X	X	X	X	X	X	X	X					YF	0
PA	I	X				X	X		X					NL	0
SD	I	X		X	X	X	X							NL	0
WA	I	X			X	X								NL	0
WI	I	X		DK		DK	X		X	X		X		NL	0
AK	NN	X		NA	NA	NA								NL	0
CO	NN	X				X								NL	0
DE	NN	X	X		X	X	X							NL	0
ME	NN	X	X		X	X								YF	0
NV	NN	X	X		X		X							NL	0
SC	NN	X	X											NL	0
WV	NN			X	X	X								NL	0
AR	NY	X		X	X	X		X	X					NL	0
ID	NY				X	DK								NL	0
KY	NY	X	X											NU	0
NM	NY					X	X							NU	0
OH	NY	X		X	X	X	X							NN	0
TX	NY	X			X	X								NL	0
WY	NY	X	X	X		X								NL	0

CODING LEGEND FOR STATE CHARACTERISTICS TABLE

Column Number	Column Title	Explanation
1	State	Standard two-character State abbreviation code.
2	Program Type	G = General estate recovery program for which we have data on recoveries, costs of recovery, and full-time equivalents (FTEs). GN = general estate recovery program for which we lack one or more of the three data elements for "G." I = program which recovers incorrectly paid benefits only. NN = no estate recovery program, none planned. NY = no estate recovery program, but considering one.
3	Verify Assets	X = State verifies--usually by checking banks--whether or not an applicant or recipient has assets even if possession of such assets is denied. Blank = State accepts denial unless strongly suspicious.
4	Identify Property	X = State verifies real property ownership and/or transfers by consulting county assessor and recorder records on all cases. Blank = State accepts applicant/recipient's denial unless strongly suspicious.
5	Divorce	X = State does not permit divorce or property dispositions which divest assets of ill spouse. Blank = divorce allowed.
6	Trusts	X = State does not permit irrevocable living trusts for purposes of obtaining Medicaid eligibility. Blank = trusts permitted.
7	Suits	X = State does not permit non-support lawsuits as a means to obtain Medicaid eligibility. This refers to suits filed by the non-institutionalized spouse to gain access to income otherwise applied toward the cost of care of an institutionalized spouse on Medicaid. Blank = Suits permitted.
8	Intent to Return	X = State requires proof, usually a medical doctor's certification, of ability to return home before a home is exempted based on "intent to return." Blank = State follows SSI/HCFA rules--no proof of intent required unless recipient's statement of intent is self-contradictory.
9	Guardians	X = State uses guardianships or other legal action to contest resource avoidance techniques. Blank = Legal action is not taken routinely.
10	Procedure	X = State has a procedure whereby it is notified of a recipient's and/or spouse's death so that estate recovery action may be taken. Blank = State has no such procedure.
11	Standing	X = State has special standing or mention in State probate law. Blank = No special position.
12	Attach	X = State attaches bank or nursing home accounts upon the death of a Medicaid recipient. Blank = State does not attach accounts.
13	Track	X = State tracks ex-recipients who leave the nursing facility in order to recover from their estates. Blank = Do not track.
14	Spouse	X = State recovers benefits received by a Medicaid recipient from the estate of the recipient's surviving spouse. Blank = No spousal recoveries.
15	Liens	Y = Liens are used during recipient's lifetime to secure property for estate recovery based on benefits correctly received. YD = Liens are used only after the recipient's death. YF = Liens are used only for recovery of benefits incorrectly received. NL = Liens are not used and State legislation would be required to permit their use. NN = Liens are not used but State legislation is not necessary. NU = Liens are not used and the need for State legislation is unknown.
16	Accounts Receivable	Amounts shown represent dollar totals owed the State based on the estate recovery of time payment vehicles such as notes, contracts and mortgages.

hand, does few estate recoveries, but has some very strong laws which abolish survivorship between joint tenants, allow the agency to petition for reformation of trusts created to attain eligibility, and make grantees liable for the uncompensated value of certain disqualifying property transfers.

Although there is no one-to-one relationship between effectiveness in estate recoveries and legal clout, it should be noted that the most effective recovery State has one of the strongest State statutory foundations. Oregon's estate recovery statutes authorize legal action to (1) appoint conservators, (2) set aside abusive property transfers, (3) attach financial accounts, (4) recover from spouses' estates and (5) file a priority claim in probate court.

Two States have noteworthy statutes on interspousal responsibility and joint tenancy. North Dakota law says:

> The parties to a marriage are mutually liable to any person who in good faith supplied either party with articles necessary for their support. Such persons may recover the reasonable value from either party except in the cases where by law one party is not liable for the support of the other.

A New Hampshire statute provides that:

> The estate of every recipient, and the estate of a recipient's spouse residing with said recipient, if any, owned severally or as joint tenants, shall be liable for all assistance granted to the recipient.

A State's authority, if any, to recover benefits from a successor's estate when the recipient dies first, is critical to maximizing potential recoveries.

Several States responded to our request for information on laws which restrict estate recoveries. In Florida, homesteads are constitutionally exempt and they inure to any heir before the State. By statute, New Jersey may not recover from estates under $3,000 nor for amounts under $500. A class action suit in California seeks to prohibit spousal recoveries. Likewise, New Mexico believes its community property statutes might preclude recoupment from a nonrecipient spouse. The State of Michigan has an attorney general's decision limiting recoveries to incorrect benefits in the absence of a State statute expressly authorizing recovery of benefits correctly received. Pennsylvania, on the other hand, prohibits recovery of correct benefits in its "welfare code," although such recoveries are authorized

in law. Alaska has no statute authorizing or forbidding estate recoveries, but public hearings on the subject led to the conclusion that "Alaskans think nursing home care is a right and that they should be able to leave assets to heirs." In one large State, where estate recovery legislation has been blocked for 2 years, the opposition did not come from the elderly, but rather from the Bar Association. The Bar in that State trains attorneys on Medicaid resource avoidance for estate planning purposes. Even Oregon limits estate recoveries in some ways. The State does not recover benefits paid for in-home care. This exception was permitted to encourage people to opt out of nursing homes and into home care. Unfortunately, the people in home care tend to be the ones who own homes and the people paid by the State to take care of them are often the same people who will inherit the homes. Thus, the State (and Federal Government) lose money on two counts.

Several State legislative initiatives are underway. California has proposed to permit a claim upon the recipient's share of a spouse's estate and to require attorneys of record to notify the State when settling the estate of a deceased past or present recipient. Massachusetts is seeking legislation to make resources which are exempt for eligibility purposes, nonexempt for purposes of estate recovery, and to require petitioners for probate to notify the State if the decedent was ever on assistance. New Jersey is trying to revise a statute which has been interpreted to preclude recovery if there is a surviving child of any age. The court case which elicited that interpretation brought New Jersey's previously aggressive estate recoveries program to its knees. Minnesota's proposed statutory changes would allow spousal recovery and permit a local agency direct access to estates under $5000--what is called an "affidavit of claiming successor" in Oregon.[20] North Dakota professes a commitment to a "legislative initiative whenever necessary to overcome adverse judicial decisions" on estate recoveries.

Several States which do not recover from estates or recover only benefits incorrectly paid are planning some legislative initiatives. Kentucky might pursue estate recoveries depending on "staffing availability and cost-effectiveness data from other States." Ohio is also reviewing cost-effectiveness. In Texas, a special State legislative

---

[20] If an estate in Oregon involves less than $35,000 in real property, less than $15,000 in personal property, or less than $50,000 combined, heirs must file an "affidavit of claiming successor" with the probate court, the revenue department, and the public assistance agency.

committee is reviewing a proposal to allow general Medicaid estate recoveries. In general, however, momentum as well as understanding, are lacking. Michigan told us, "Every year we submit our over-65 probate legislation. The legislature refuses to pass it. They call it the 'vulture bill.' Every year I get up and testify along with eligibility staff and every year they vote it down. We can never muster enough support to get the bill out of committee on either the House or Senate side."

State Recommendations on Estate Recoveries

Five of the changes which States recommended in Federal law and policy to enhance estate recoveries had to do directly with estate recoveries as opposed to transfer of assets and liens. The most frequent recommendation was that estate recoveries should be made mandatory. Seven States made this suggestion. An eighth State, Kentucky, recommended eliminating all Federal restrictions on estate recoveries. A ninth, North Dakota, felt strongly that the Federal Government should not force any particular recovery process on the States and should encourage flexibility. Rhode Island made a common observation that people "beat the system all the time" and clear legislation is needed to make sure that those who are able, pay back the Medicaid program for the benefits they receive.

Three States recommended that technical assistance be provided on how to establish and operate Medicaid estate recovery programs. Specific requests included guidance on record keeping, establishing and filing claims, automated recovery techniques, recovery in large States with many counties, and sample forms.

Five States thought the Federal Government should provide incentives to the States to establish Medicaid estate recovery programs. All of these recommendations involved giving States a disproportionate share of estate recoveries compared to their Federal Medical Assistance Percentage (FMAP) or matching rate. For example, States might be allowed to retain half of all recoveries even though the original benefits were funded with 70 percent Federal and only 30 percent State funds. From the Federal perspective, one wonders why this kind of encouragement would be needed when States can recover easily at a rate of $10 or $15 to $1. On the other hand, Minnesota used incentives very successfully to animate its county administered program. Although the counties contribute only 5 percent of the cost of Medicaid in Minnesota (45 percent comes from the State and 50 percent from the Federal Government), they are allowed to keep 25 percent of all recoveries (25 percent goes to the State and 50 percent to the Federal Government).

This incentive system may help to account for Minnesota's third place rank among Medicaid estate recovery programs.

There has been some argument whether Federal statute permits recovery of correct benefits received before age 65 by an institutionalized recipient. The law clearly prohibits recoveries of benefits received before age 65 by noninstitutionalized recipients. In general, most States have acted as though no benefits received before age 65 may be recovered from anyone. Thus, eight States recommended permitting recovery of benefits received at any age.

The final State recommendation relates to both transfer of assets and estate recoveries. Four States said we need to find a way to handle "joint tenancy with right of survivorship." The problem is that when property is held in joint tenancy, the property goes to the other tenant when either tenant dies without an estate being probated. Joint tenancy ownership may occur between nonspouses as well as spouses. There is strong indication that people are using joint tenancy in both real and personal property to avoid public assistance resource limitations as well as to prevent estate recoveries. You cannot collect from an estate when property passes automatically to a nonliable joint tenant with no estate filed. Once the property is in the joint tenant's possession with full ownership status, the State may no longer have a claim. With regard to setting up joint accounts to which a Medicaid applicant/recipient has no access without the consent of the joint owner, thereby excluding the account from eligibility resource limitations, one State said, "This is the biggest loophole in the regulations. You could drive an 18-wheeler through it." States recommended making the applicant/recipient's property, which is held in joint tenancy, available for purposes of eligibility and/or recoverable after the recipient's death, when the remainderman either dies or tries to transfer the property. Medicaid eligibility conditional upon liens or "voluntary mortgages" might achieve this purpose.

Montana capsulized the 70 recommendations we received from 34 States:

> "Applying transfer of assets restrictions to exempt property, applying liens in all cases, and recovering benefits received at any age would remove most of the limitations and allow Medicaid estate recoveries to be multiplied by factors of three, four or five.".

CONCLUSION

Despite the asset control authorities granted by Congress in TEFRA, many elderly people with moderate to large assets still receive Medicaid. With few exceptions, their property remains unencumbered during the period of eligibility which may include years of nursing home institutionalization. Most Medicaid recipients have no legal responsibility to pay back the cost of their publicly-funded care when they and their dependents no longer need the exempted property. Based on evidence from State Medicaid staff and the legal literature on estate planning (see the Bibliography), it appears that well-to-do people with access to attorneys and accountants are the most likely to be able to avoid public assistance resource limitations.

Although Medicaid's expensive long-term care benefit is available to people with sizeable assets, the program encompasses only a relatively small percentage of the nation's poor.

> Nationally, Medicaid covers only 35.8 percent of poor elderly persons, 34.0 percent of poor adults between the ages of eighteen and sixty-four, and 49.5 percent of those under age eighteen. (Holahan and Cohen, p. 99)

A recent Urban Institute book concluded that "Medicaid was originally conceived as a way of broadening the public provision of medical services to the poor and of ensuring more uniformity in service provision among the states...but over the years Medicaid has increasingly concentrated on providing long-term institutional care to the elderly and the disabled, many of whom are not officially poor." (Holahan and Cohen, p. 1)

Our findings show that States currently recover less than $42 million per year from the estates of deceased Medicaid recipients. If all States recovered at the same rate as the most effective State (Oregon), national recoveries would be $589 million annually. Current laws, regulations, and policies, as we have observed however, make estate recoveries very difficult. If the recommendations in the following section were implemented, some State Medicaid staff believe that the current potential of Medicaid estate recoveries could be augmented by a factor of three, four or five. When we consider that (1) the total home equity of the elderly in

the United States is $750 billion,[21] (2) Medicaid exempts homes, and (3) catastrophic long-term illness strikes all economic levels, it is plausible that Medicaid estate recoveries could generate very large sums indeed. (See the illustration which follows this section.)

A large nontax revenue source generated by Medicaid estate recoveries could be recycled to help the truly destitute. It is possible, however, that enhanced estate recoveries would have more far-reaching effects on long-term care funding. Faced with the certainty--which is almost nonexistent today--that accepting care from Medicaid means paying back the cost out of one's estate, people might seek other alternatives. Such alternatives include Social Health Maintenance Organizations (SHMO's), continuing care communities, targeted savings accounts and private long-term care insurance. To pay for these nonpublic assistance options, the elderly would have to turn more to private home equity conversion[22] or to assistance from their adult children.[23] It is their children, after all, who stand to inherit whatever property remains after the costs of long-term care are paid and who currently reap the windfall of Medicaid

---

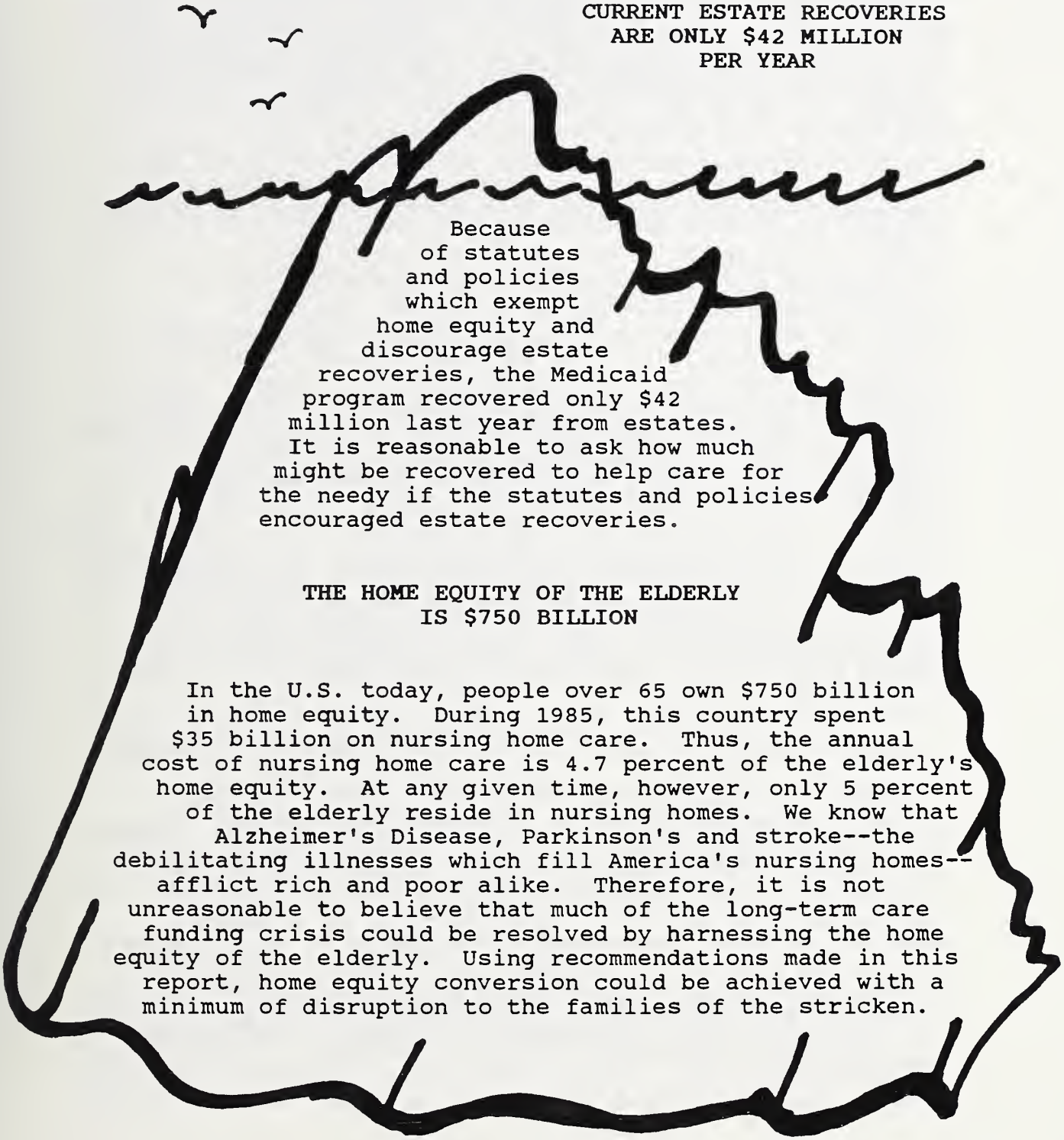
[21] "Seventy-five percent of Americans 65 and older own their homes, with the vast majority owning outright, reports The Commonwealth Fund. The average value of the 13 million homes owned by senior citizens is $60,000, for an estimated total equity of more than $750 billion." (Long Term Care Management Newsletter, p. 8)

[22] Reverse mortgages and sale/leasebacks, the principle vehicles of home equity conversion, have not been highly popular in the marketplace. "Current Medicaid eligibility rules discourage the use of home equity to finance long-term care by making the home a protected asset." (United States Congress, Office of Technology Assessment, p. 450) In the absence of such protection, people might be more inclined to tap their home equity to pay for private long-term care insurance premiums. The interested reader should consult the National Center for Home Equity Conversion in Madison, Wisconsin.

[23] Home equity conversion and help from adult children could readily be combined. More and more frequently, we see adult children buying their parents' homes in a familial sale/leaseback arrangement. The children do this for a tax write-off. Proceeds from the sale augment the parents' income and could be used to purchase long-term care insurance.

subsidies. We must emphasize that the issue is enrichment of nonneedy adult heirs, not denial of care to the elderly. For those who opt to rely on Medicaid, or have no other choice, eligibility conditional upon a promise (secured by an automatic lien) to repay benefits from their estates would assure all elderly people of (1) access to care, (2) retention of home property as long as it is needed by spouse and dependents, and (3) the dignity of paying their own way in the end.

MEDICAID ESTATE RECOVERIES ARE ONLY THE TIP OF THE ICEBERG



CURRENT ESTATE RECOVERIES ARE ONLY $42 MILLION PER YEAR

Because of statutes and policies which exempt home equity and discourage estate recoveries, the Medicaid program recovered only $42 million last year from estates. It is reasonable to ask how much might be recovered to help care for the needy if the statutes and policies encouraged estate recoveries.

THE HOME EQUITY OF THE ELDERLY IS $750 BILLION

In the U.S. today, people over 65 own $750 billion in home equity. During 1985, this country spent $35 billion on nursing home care. Thus, the annual cost of nursing home care is 4.7 percent of the elderly's home equity. At any given time, however, only 5 percent of the elderly reside in nursing homes. We know that Alzheimer's Disease, Parkinson's and stroke--the debilitating illnesses which fill America's nursing homes--afflict rich and poor alike. Therefore, it is not unreasonable to believe that much of the long-term care funding crisis could be resolved by harnessing the home equity of the elderly. Using recommendations made in this report, home equity conversion could be achieved with a minimum of disruption to the families of the stricken.

RECOMMENDATIONS

Recommendations number 1 through number 4 are the responsibility of the Health Care Financing Administration. Implementation of these recommendations will require some policy, regulation and statutory changes. Statutory changes will require the preparation of a legislative proposal by the HCFA followed by departmental approval. Recommendation number 5 is the reponsibility of the Office of Inspector General.

The HCFA reviewed and commented on a draft of this report. We met with representatives of the agency to discuss their comments. We will continue to confer with HCFA on related issues.

This report has also received close scrutiny from an intradepartmental work group on estate recoveries. The work group raised many questions which point toward further research and analysis. For example, we are exploring a proposal to tighten the "intent to return" rules instead of easing or eliminating them as proposed here. This would increase the pressure on people to sell homes and spend down, but would eliminate the need to recover home equity from estates. Another idea under review is governmentally sponsored home equity conversion. The proposal is to give people a publicly insured line of credit on their homes which they can use for home care, institutional care, or long-term care insurance premiums. The family would pay back public costs, up to but not exceeding the value of the property secured, after the deaths of the beneficiary and all dependent relatives. These ideas and many other related issues will be explored further in forthcoming OIG studies.

RECOMMENDATION #1--ELIGIBILITY AND TREATMENT OF RESOURCES

FINDING: Some HCFA, SSI, and State Medicaid policies promote retention of assets during Medicaid eligibility while others encourage precipitous liquidation of property with concomitant losses in value. Assets retained by recipients, in the absence of estate recovery programs, pass unencumbered to heirs at the expense of the taxpayers. Assets liquidated, sheltered or concealed to obtain eligibility are lost as a long-term care funding resource also. Incapacitated elderly people are sometimes financially abused by people who want to take their property, while at the same time, qualifying them for Medicaid nursing home benefits.

RECOMMENDATION: Change Medicaid rules to permit families to retain and manage property while their elders receive long-term care. Specifically: eliminate SSI "intent to return" rules as they apply to Medicaid long-term care recipients. Reinstate and broaden the "bona fide effort to sell" exemption. Allow Medicaid recipients to retain more income-producing property such as "contracts of deeds" or rental homes. Require agreement to liens and estate recoveries as a condition of Medicaid eligibility for people with property. Encourage State Medicaid programs to protect recipients and their property from financial exploitation through conservatorships, legal representation, and property management when necessary.

IMPACT: This policy would ease the financial impact of catastrophic long-term care costs on the elderly and their families, giving them time to cope with the problem. Total Medicaid costs would decline as estate recoveries increase.

RECOMMENDATION #2--TRANSFER OF ASSETS

FINDING: Despite almost universal State implementation of the TEFRA authority to restrict transfers of assets for the purpose of obtaining Medicaid eligibility, people are still able to give away property to qualify for assistance. This may be done by using the legal "loopholes" recommended in law journal articles or by deceit and concealment.

RECOMMENDATION: Strengthen the transfer of assets rules so that people cannot give away property to qualify for Medicaid. Specifically: improve State verification of property and transfers. Clarify that the "transfer of assets" restrictions apply to all property including that which is, or would be, exempt from eligibility determination. Expressly prohibit the transfer of property to spouses and other dependents which is permitted under current law. Extend the current 2-year "look-back" period to 5 or more years. Have HCFA publish regulations on transfer of assets.

IMPACT: More property will be retained by recipients to reimburse Medicaid for their cost of care after they and their dependents are no longer in need.

RECOMMENDATION #3--LIENS

FINDING: State Medicaid programs need a way to track property owned by recipients and ensure that it is not transferred or otherwise disposed before recovery of Medicaid benefits can be accomplished. Liens achieve these objectives most efficiently. While permitting liens, TEFRA

placed so many qualifications on their use that only two States have employed liens to secure property for recovery of benefits correctly paid.

RECOMMENDATION: Require a legal instrument as a condition of Medicaid eligibility to secure property owned by applicants and recipients for later recovery. Specifically: Make liens, or some other form of encumbrance, a condition of eligibility so that the recipient's interest in any property solely or jointly owned will inure, up to the cost of care paid by Medicaid, to the Medicaid program when neither the recipient nor dependents need the property further. Promote home equity conversion by using liens, "voluntary mortgages," "open-ended mortgages," and accounts receivable to let people extract their equities gradually while they receive assistance.

IMPACT: Mandatory liens would secure the State and Federal Government's investment and permit Medicaid recipients to retain needed property while receiving highly expensive, but essential care.

RECOMMENDATION #4--ESTATE RECOVERIES

FINDING: Less than half of the States pursue Medicaid estate recoveries for benefits correctly paid. Of those which do, a few are very effective, but most are not. The HCFA and State Medicaid managements place little emphasis on retention of recipient property or estate recoveries. The TEFRA authority for estate recoveries, as for transfer of assets restrictions and liens, is only voluntary. Many State staff believe that TEFRA limitations hobble estate recoveries without safeguarding legitimate recipient interests.

RECOMMENDATION: Increase estate recoveries as a nontax revenue source for the Medicaid program while steadfastly protecting the property rights of recipients and their dependents. Specifically: Make estate recovery programs mandatory like other forms of third party liablity. Provide technical assistance on estate recoveries, so that States can implement quickly and easily to generate an immediate cash flow for the Medicaid program. Promote awareness of the importance of real property ownership and estate recoveries for Medicaid funding. Allow estate recovery of benefits received before age 65. Permit estate recovery in cases of joint tenancy with right of survivorship. Require spousal and dependent recoveries upon death or seniority (of a minor child.)

IMPACT: Based on Oregon's experience--even under current restrictive laws, regulations and policies--estate

recoveries can recoup 5.2 percent of Medicaid nursing home costs, 5.0 percent of Medicaid payments to people over age 65, and 1.7 percent of total Medicaid vendor payments. With enhanced legal authorities and greater programmatic emphasis, the contribution of estate recoveries to Medicaid's program resources could be truly staggering.

RECOMMENDATION #5--FUTURE STUDIES

FINDING: We have a great deal of circumstantial evidence about public assistance resource avoidance and estate planning to qualify for Medicaid. No hard data are available, however, on the extent of these practices. We also are unaware of how much Federal money is spent by the Legal Services Corporation and other national programs to promote Medicaid eligibility for people with property. We cannot account, without further review, for large discrepancies in amounts of estate recoveries reported to us versus "probate recoveries" reported to HCFA (for purposes of reimbursing the Federal share of recoveries.) Finally, a priori, it would seem that the ability to receive Medicaid while preserving assets is a strong disincentive to the purchase of private long-term care insurance. Is this true, and if so, would programmatic changes such as those recommended here remove the disincentive and promote nonpublic assistance options to funding long-term care?

RECOMMENDATION: At a minimum, the following actions should be taken:

- Conduct a comprehensive study of the transfer of assets problem to estimate how much equity is being diverted from long-term care costs at the expense of the Medicaid program. To what extent is the Federal Government funding this diversion by training attorneys and counseling prospective Medicaid recipients?

- Conduct a thorough audit of Medicaid estate recovery programs to determine if the Federal Government is receiving its full share of the proceeds.

- Perform a review to determine whether the availability of Medicaid without encumbering assets has a chilling effect on the marketability of private sector risk-sharing products such as long-term care insurance.

IMPACT: Results of these studies could point the way to a more equitable and efficient utilization of economic resources for the satisfaction of catastrophic long-term care needs.

BIBLIOGRAPHY

_____, "Comments: The Effect of Asset Transfers on Medicaid Eligibility," University of Pennsylvania Law Review, Vol. 129, April 1981, pps. 882-910.

_____, "Parents in Nursing Homes: A New Burden for Kids?," 50 Plus, December 1983, Vol. 23, No. 12, p. 9.

_____, "Who Can Afford a Nursing Home?," Consumer Reports, May 1988, pps. 300-311.

Adler, Michelle, Suzanne Kitchen, and Albert Irion, Databook on the Elderly: A Statistical Portrait, Macro Systems, Inc., for the Department of Health and Human Services under Task Order Contract No. HHS-100-84-0036, 1987.

American Association of Retired Persons, "A Profile of Older Americans," Washington, D.C., 1986.

American Association of Retired Persons, "Before You Buy: A Guide to Long-Term Care Insurance," 1987

American Association of Retired Persons, Long-Term Care Research Study, January 30, 1984.

American Association of Retired Persons, Preferences of AARP Members for Specific Long-Term Care Insurance Product Features, Towers, Perrin, Forster and Crosby, February 28, 1985.

American Bar Association, "Doing Well by Doing Good: Providing Legal Services to the Elderly in a Paying Private Practice," Commission on Legal Problems of the Elderly, Washington, D.C., 1985.

American Council of Life Insurance, 1986 Life Insurance Fact Book, Washington, D.C., 1987.

American Council of Life Insurance, "Growing Older in America: How the Baby Boomers' Parents View Retirement," Council Review, September 1985.

Avery, Robert B., et. al., "Survey of Consumer Finances, 1983," Federal Reserve Bulletin, September 1984, pps. 679-692. This survey was a joint project of the Board of Governors of the Federal Reserve System, the Department of Health and Human Services, and five other federal agencies.

Avery, Robert B., et. al., "Survey of Consumer Finances, 1983: A Second Look," Federal Reserve Bulletin, December 1984.

Bisbee, Gerald E., Jr., "Long-Term Care Insurance: Separating Fact from Fiction, An Investment Banker's Point of View," Contemporary LTC, May 1987.

Bisbee, Gerald E., Jr. and Mark J. Simon, "Is Long-Term Care Insurance a Panacea?", Provider, Vol. 13, No. 6, June 1987, pps. 16-19.

Branch, Laurence G., "Impoverishment for the Elderly: A Case Study of Financial Risk," America's Health Care Challenge: New Directions for Business, Government and Individuals, Northwestern National Life Insurance Company, 1986, pps. 14-18.

Brickfield, Cyril F., "Coverage Won't Ensure Service Availability," Provider, Vol. 13, No. 6, June 1987, pps. 19-20.

Brickfield, Cyril F., "Long-Term Care Financing Solutions Are Needed Now," American Health Care Association Journal, Vol. 11, No. 6, October 1985, pps. 11-15.

Brickfield, Cyril F., "Who Will Pay for Long-Term Care," Caring, Vol. IV, No. 3., March 1985, pps. 23-26.

Burwell, Brian O., Shared Obligations: Public Policy Influences on Family Care, Systemetrics/McGraw-Hill, Inc., under a subcontract to HCFA Contract No. 500-83-0056, May 1986.

Carpenter, Letty, Medicaid Eligibility for Persons in Nursing Homes, Health Care Financing Administration, unpublished draft, January 26, 1988.

Clark, Robert L. and Daniel A. Sumner, "Inflation and the Real Income of the Elderly: Recent Examples and Expectations for the Future," The Gerontologist, Vol. 25, No. 2, 1985, p. 146.

Coberly, Sally, "Financing Catastrophic Long-Term Health Care Expenses of the Elderly: The Role of Private Long-Term Care Insurance," background paper for the Assembly Special Committee on Medi-Cal Oversight of the State of California, UCLA-USC Long-Term Care Gerontology Center, January 1986.

Coberly, Sally, "Long-Term Care Insurance: Problems and Prospects," background paper prepared for the South Carolina Health and Human Services Finance Commission, Andrus

Gerontology Center, University of South California, Los Angeles, California, March 1985.

Cohen, Marc A., Eileen J. Tell and Stanley S. Wallack, "The Lifetime Risks and Costs of Nursing Home Use Among the Elderly," Medical Care, Vol. 24, No. 12, December 1986, pps. 1161-1172.

Cohen, Marc A., et. al., "The Financial Capacity of the Elderly to Insure for Long-Term Care," The Gerontologist, Vol. 27, No. 4, 1987, pps. 494-502.

Commonwealth Fund and ICF Incorporated, Old, Alone and Poor: A Plan for Reducing Poverty Among Elderly People Living Alone, Commonwealth Fund, April 16, 1987.

Council of Economic Advisors, "Chapter 5: Economic Status of the Elderly," The Annual Report of the Council of Economic Advisers, United States Government Printing Office, Washington, D.C., 1985, pps. 159-186.

Crumb, Barbara, project director, Spousal Impoverishment Related to Residential Health Care Placement, New York Department of Social Services, recent but undated.

Cunningham, James E., "Long-Term Care Insurance and Us--Perfect Together," American Health Care Association Journal, Vol. 11, No. 6, October 1985, pps. 26-28.

Curtis, Richard E. and Lawrence R. Bartlett, "High Cost of Long-Term Care Squeezes State Budgets," Caring, Vol. IV, No. 3., March 1985, pps. 28-31.

Curtis, Rick, John Luehrs and Diane Justice, editors, Building Affordable Long-Term Care Alternatives, National Governors' Association Center for Policy Research, Washington, D.C., April 1987.

Davidson, Stephen M., Jerry Cromwell and Rachel Schurman, "Medicaid Myths: Trends in Medicaid Expenditures and the Prospects for Reform," Journal of Health Politics, Policy, and Law, Vol. 10, No. 4, Winter 1986, pps. 699-728.

Davis, Clayton, "Solving Common Problems in Long-Term Care and Medicaid Financial Eligibility," The Alabama Lawyer, Volume 46, Number 6, November 1985.

Deford, Gill, "Medicaid Liens, Recoveries, and Transfer of Assets after TEFRA," Clearinghouse Review, June 1984.

Delbaum, Charles M., "Financial Planning for Nursing Home Care: Medicaid Eligibility Considerations," Ohio State Bar

Association Report, Volume 57, Number 14, April 2, 1984, pps. 372-381.

Department of Health and Human Services, Catastrophic Illness Expenses, report to the President, November 1986.

Department of Health and Human Services, Report of the Task Force on Long-Term Health Care Policies, U. S. Government Printing Office, Washington, D.C., September 21, 1987.

Doty, Pamela, Korbin Liu and Joshua Wiener, "An Overview of Long-Term Care," Health Care Financing Review, Vol. 6, No. 3, Spring 1985, pps. 69-78.

Doty, Pamela, "Long-Term Care for the Middle-Income Elderly: Options for Increased Private Financing," unpublished paper by HCFA policy analyst, 1986.

Doty, Pamela, "The Politics of Long-Term Care Insurance: Is Medicaid a Deterrent to Private Coverage," unpublished manuscript by DHHS analyst, 1987.

Duncan, Glen, "Public Attitudes About Contingency Planning for Long-Term Care Needs," Beverly Foundation, July 1986.

Dunn, Donald H., "Easing the Burden of Nursing Home Costs," Business Week, No. 2883, March 11, 1985.

Editors of Caring, "Editorial Introduction: Long-Term Care Insurance," Caring, Vol. IV, No. 3., March 1985, pps. 3-11.
Employee Benefit Research Institute, "Issue Brief: Financing Long-Term Care," No. 48, November 1985.

Federal Council on the Aging, Health Care Study for Older Americans: A Staff Report, DHHS Publication No. (OHDS) 86-20961, 1985.

Feinstein, Patrice Hirsch, Marian Gornick, and Jay N. Greenberg, editors, Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives: Conference Proceedings, Health Care Financing Administration, Washington, D.C., January 24, 1984.

Feldman, Penny H. and Margaret Gerteis, "Private Insurance for Medicaid Recipients: The Texas Experience," Journal of Health Politics, Policy and Law, Vol. 12, No. 2, Summer 1987, pps. 271-298.

Forman, Frank, Shirley A. Hanson, Ron Johnson, and Dale M. Larson (long-term care insurance entrepreneurs, two of whom--underlined--have companies located in Bellevue, Washington) "Convincing the Consumer to Buy," American Health Care

Association Journal, Vol. 11, No. 6, October 1985, pps. 16-18.

Freudenheim, Milt, "Business and Health: Nursing Home Insurers Rise," The New York Times, March 17, 1987.

Frontline, "What About Mom and Dad," May 21, 1985, Program #320.

General Accounting Office, "An Aging Society: Meeting the Needs of the Elderly While Responding to Rising Federal Costs," GAO/HRD-86-135, September 1986.

General Accounting Office, "Long-Term Care Insurance: Coverage Varies Widely in a Developing Market," GAO/HRD-87-80, May 1987.

General Accounting Office, "Medicaid and Nursing Home Care: Cost Increases and the Need for Services are Creating Problems for the States and the Elderly," GAO/IPE-84-1, October 21, 1983.

Glenn, Karen, "Health Care Spending: Growing Through the Year 2000," Medicine and Health: Perspectives, Vol. 41, No. 25, June 22, 1987.

Greenfield, Peter and Barbara A. Isenhour, "Medicaid for Nursing Home Care: Some Estate Planning Considerations," Washington State Bar News, Volume 40, Number 6, June 1986.

Grimaldi, Paul L., "Long-Term Care Policies: Defusing a Financial Time Bomb," Health Progress, November 1987, pps. 33-40.

Grossman, Steven A., Chairman, Technical Work Group, Report to the Secretary on Private Long-Term Care for the Elderly, draft, November 1986.

Gunter, Bill, "A Regulator's Response to Long-Term Care Financing," American Health Care Association Journal, Vol. 11, No. 6, October 1985, pps. 22-23.

Hansen, Karen, editor, Long-Term Care for the Elderly: A Legislator's Guide, National Conference of State Legislatures, Washington, D.C., May 1987.

Hay, Joel W. and Richard L. Ernst, "The Economic Costs of Alzheimer's Disease," American Journal of Public Health, Vol. 77, No. 9, September 1987, pps. 1169-1175.

Health Care Financing Administration, "20 Years of Medicare and Medicaid," Health Care Financing Review, 1985 Annual Supplement, December 1985.

Health Care Financing Administration, Grants and Contracts Report, Short Term Evaluation of Medicaid: Selected Issues, especially Chapter 4, "Institutionalized Recipients," pps. 121-152, October 1984, Contract No. HHS-100-82-0038.

Health Care Financing Administration, Grants and Contracts Report: A Decade of Medicaid Experience, Fiscal Years 1973 through 1982, Baltimore, Maryland, September 1985, HCFA Grant No. 18-P-97265/5-05. Any citations in the text are to the 1984 edition unless this 1985 edition is expressly mentioned.

Health Care Financing Administration, "National Health Expenditures, 1985," Health Care Financing Notes, Number 6, September 1986, Health Care Financing Administration Publication No. 03232.

Health Care Financing Administration, Office of the Actuary, Division of National Cost Estimates, "National Health Expenditures, 1986-2000," Health Care Financing Review, Vol. 8, No. 4, Summer 1987, pps. 1-36.

Health Care Financing Administration, "Report to Congress: Study of Health Insurance Designed to Supplement Medicare and Other Limited Benefit Health Insurance Sold to Medicare Beneficiaries," HCFA Publication No. 03256, September 1987.

Health Care Financing Administration, "The Medicaid Estate Recoveries Study, draft report prepared by region X in 1985, unpublished.

Health Insurance Association of America, "Conference on Long-Term Care: Proceedings," Washington, D.C., December 4, 1984.

Health Insurance Association of America, "Long-Term Care: The Challenge to Society," publication of the Public Relations Division, 1984.

Hereford, Russ and Bruce Spitz, "Transfer of Assets: State Practices, Issues and Options," unpublished, prepared for the Medicaid Cost Containment Commission, State of Connecticut, December 1983.

Hing, Esther, "Use of Nursing Homes by the Elderly: Preliminary Data From the 1985 National Nursing Home Survey," NCHS Advancedata, No. 135, May 14, 1987.

Holahan, John F. and Joel W. Cohen, Medicaid: The Trade-off Between Cost Containment and Access to Care, The Urban Institute Press, Washington, D.C., 1986.

Hoover, James B. and Jerry Balter, "Long-Term Care Insurance: An Emerging Growth Opportunity for the Nursing Home Industry," Robertson, Colman and Stephens, (Investment Bankers), institutional research paper, July 29, 1986.

ICF, Incorporated, "Policy Options for Long-Term Care," final report submitted to the American Health Care Association, May 15, 1987.

ICF Incorporated, Private Financing of Long-Term Care: Current Methods and Resources, final report to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, January 1985.

Intergovernmental Health Policy Project, "State Legislation and Regulations Related to Long-Term Care Insurance," Focus On..., No. 15, February 1987.

Issacs, Joseph C. and Stephanie Tames, Long-Term Care: In Search of a National Policy, National Health Council, Inc., New York, New York, December 1986.

Jacobs, Bruce and William Weissert, "Home Equity Financing of Long-Term Care for the Elderly," in Conference Proceedings, Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives, January 24, 1984, Washington, D.C., published by the Health Care Financing Administration, Publication No. 03174.

Jacobs, Bruce and William Weissert, "Using Home Equity to Finance Long-Term Care," Journal of Health Politics, Policy and Law, Vol. 12, No. 1, Spring 1987, pps. 77-95.

Jazwiecki, Tom, "Long-Term Care Financing Options for the Future," American Health Care Association, unpublished paper presented by Robert T. Deane at the Third National Leadership Conference on Long-Term Care Issues, March 7-9, 1984.

Jennings, Marian C. and Susanna E. Krentz, "Private Payment for Long-Term Care: The Untapped Mechanism," Topics in Health Care Financing, Spring 1984.

Keeffe, Patrick, "Ten Questions to Ask Your Parents," Money Magazine, March 1985.

Kennell, David L., "Can the Elderly Afford Long-Term Care Insurance," American Health Care Association Journal, Vol. 11, No. 6, October 1985, pps. 6-8.

Knickman, James, et. al., "Increasing Private Financing of Long-Term Care: Opportunities for Collaborative Action," prepared for SRI International, August 1985.

Kosterlitz, Julie, "Health Focus," National Journal, No. 35, August 29, 1987, p. 2187.

Kunerth, Alan M., "Group LTC Insurance as a Marketing Tool," Contemporary Long-Term Care, Vol. 10, No. 12, pps. 38ff.

Ladd, Richard C., "Perceived Problems and Suggested Solutions Related to Long-Term Care Insurance," unpublished paper by the Administrator of Oregon's Senior Services Division, January 12, 1987.

Lane, Laurence F., "Private Long-Term Care Insurance," Long-Term Care Currents, Vol. 8, No. 3, 1985.

Lane, Laurence F., "Shaping Long-Term Care Insurance in the States," American Health Care Association Journal, Vol. 11, No. 6, October 1985, pps. 24-26.

Lane, Laurence F., summary of the proceedings of the AARP/AHCA/NAHC/NGA conference on "Private Long-Term Care Insurance: The Emerging Market," November 21-22, 1985, San Francisco, California.

Lane, Laurence F., "The Potential of Private Long-Term Care Insurance," Pride Institute Journal of Long-Term Home Health Care, Vol. 4, No. 3, Summer 1985, pps. 15-21.

Leutz, Walter, "Long-Term Care for the Elderly: Public Dreams and Private Realities," Inquiry, Vol. 23, Summer 1986, pps. 134-140.

Libassi, F. Peter, Chairman, Governor's Commission on Private and Public Responsibilities for Financing Long-Term Care for the Elderly, How Will We Pay?, final report, June 1, 1987.

Lifeplans, Inc., "Private Long-Term Care Insurance: Issues, Options and Potential," prepared for American Association of Homes for the Aging, Waltham, MA.

Lifson, Arthur, "Financing Long-Term Care: HIAA's Evaluation," Health Care Financial Management, Vol. 38, No. 3, March 1984.

Lifson, Arthur, "Long-Term Care: An Insurer's Perspective," in Conference Proceedings: Long-Term Care Financing and Delivery Systems: Exploring Some Alternatives, Health Care Financing Administration, United States Government Printing Office, Washington, D.C., 1984.

Long-Term Care Management Newsletter, Volume 16, Number 7, McGraw-Hill, Washington, D.C., April 2, 1987.

Maag, Stephen J., "Consumer Confidence Increases Marketability," American Health Care Association Journal, Vol. 11, No. 6, October 1985, pps. 28-29.

Manton, Kenneth G. and Korbin Liu, "The 1982 and 1984 National Long-Term Care Surveys: Their Structure and Analytic Uses," unpublished, prepared for National Conference on Long-Term Care Data Bases, May 21-22, 1987, Washington, D.C.

Matula, Barbara, "The Cost of Caring for Long-Term Illness: The Case for Insurance," America's Health Care Challenge: New Directions for Business, Government and Individuals, Northwestern National Life Insurance Company, 1986, pps. 32-34.

Meiners, Mark R., "Enhancing the Role of Private Insurance in the Public Responsibility for Long-Term Care: Strategies for State Action," unpublished draft, January 29, 1988.

Meiners, Mark R., "Long-Term Care Insurance: An Idea Whose Time Has Come," America's Health Care Challenge: New Directions for Business, Government and Individuals, Northwestern National Life Insurance Company, 1986, pps. 36-42.

Meiners, Mark R., "Shifting the Burden: The Potential Role of the Private Sector in Long-Term Care Insurance for the Elderly," American Health Care Association Journal, March 1982, pps. 20-22.

Meiners, Mark R., "The Case for Long-Term Care Insurance," Health Affairs, Vol. 2, No. 2, Summer 1983, pps. 55-79.

Meiners, Mark R., "The State of the Art in Long-Term Care Insurance," National Center for Health Services Research, Washington, D.C., 1984.

Meiners, Mark R. and James O. Gollub, "Long-Term Care Insurance: The Edge of An Emerging Market," Caring, Vol. IV, No. 3., March 1985, pps. 12-16.

Meiners, Mark R. and Arlene K. Tave, "Consumer Interest in Long-Term Care Insurance: A Survey of the Elderly in Six States," draft article, National Center for Health Services Research, February 15, 1985.

Meiners, Mark R. and Arlene K. Tave, "Predicting the Determinants of Demand for Long-Term Care Insurance," draft

article, National Center for Health Services Research, December 7, 1984.

Meiners, Mark R. and Gordon R. Trapnell, "Long-Term Care Insurance Premium Estimates for Prototype Policies," Medical Care, Vol. 22, No. 10, October 1984, pps. 901-911.

Moran, Donald W. and David Kennell, "Restructuring Long-Term Care Financing," Provider, Vol. 13, No. 6, June 1987, pps. 21-25.

Muse, Donald N., "Strategies to Promote Private Financing Options: Medicaid Reform," paper prepared for the Governor's Commission on Private and Public Responsibilities for Financing Long-Term Care for the Elderly, State of Connecticut, May 22, 1987.

Myder, Janet A., "Long-Term Care Insurance: It Still Has a Long Way to Go," Provider, February 1988.

Myder, Janet, "Private Long-Term Care Insurance: The Maturing Market," Conference Sessions and Technical Symposia, Summary of Proceedings, American Health Care Association, based on third annual national conference on private long-term care insurance January 13-14, 1987, in San Antonio, Texas.

National Association of Insurance Commissioners (NAIC), Long-Term Care Insurance: An Industry Perspective on Market Development and Consumer Protection, 1987.

National Center for Health Statistics, Health, United States, 1987, DHHS Pub. No. (PHS) 88-1232, Public Health Service, Washington, D.C., Government Printing Office, March 1988.

National Chamber Foundation, Private Sector Task Force on Catastrophic and Long-Term Health Care Alternatives, Private Sector Policy Options for Addressing Catastrophic and Long-Term Health Care Needs, Washington, D.C., July 28, 1986.

National Health Law Program (Roger Schwartz), "New COBRA Legislation Adopts Many Changes in Medicaid and Other Health Programs," Clearinghouse Review, Volume 20, Number 3, July 1986.

National Senior Citizens Law Center, "Medicaid Transfer of Assets Update: HHS Tries to Control the Hydra," Clearinghouse Review, October 1982, pps. 431-433.

Neuschler, Edward, Medicaid Eligibility for the Elderly in Need of Long-Term Care," National Governors' Association Center for Policy Research, Washington, D.C., September 1987.

Newland, Jane, "Long-Term Care Financing: Will it Bury Tax Reform?," Hospitals, March 5, 1987, pps. 42-48.

Office of Inspector General, Office of Audit, "Draft of a Proposed Report on Recovery of Past Medicaid Payments From Estates of Deceased Recipients," Audit Report Number A-05-86-60249, December 23, 1986.

Oriol, William E., The Complex Cube of Long-Term Care, American Health Planning Association, Washington, D.C., 1985.

Oviatt, Carol C., Private Health Insurance Coverage for Long-Term Care Services, Institute for Health Planning, Madison, Wisconsin, December 1983.

Payne, John B., Jr., "Medicaid Asset and Divestment Policy," Michigan Bar Journal, January 1987.

Pepper, Claude, "Insuring the Dignity of the Individual," American Health Care Association Journal, Vol. 11, No. 6, October 1985, pps. 3-5.

Pollack, Ronald F., "Health Care and the Economics of Old Age," Provider, Vol. 13, No. 6, June 1987, pps. 12-15.

Press, Stephen H., "Insurance: Alternative Funding Source," American Health Care Association Journal, Vol. 11, No. 6, October 1985, pps. 33-36.

Response Analysis Corporation, Long-Term Care Coverage: How Fast is the Market Growing, "Volume 1: Executive Summary and Implications," Princeton, New Jersey, February 1987, pps. i-xxvi.

Rice, Thomas and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," Health Affairs, Vol. 5, No. 4, Winter 1986, pps. 6-21.

Roche, "The Cost and Availability of Nursing Home Care," Health Policy Report, Vol. 1, No. 2, Spring 1987.

Rowland, Don, "Division of Assets: A Status Report," The Journal of the Kansas Bar Association, Vol. 55, No. 7, September/October 1986, pps. 4-5.

Ruggles, Patricia and Marilyn Moon, "The Impact of Recent Legislative Changes in Benefit Programs for the Elderly," The Gerontologist, Vol. 25, No. 2, 1985, p. 156.

Sabatino, Charles P., "An Advocate's Primer on Long-Term Care Insurance," Clearinghouse Review, Special Issue, Summer, 1986.

Scanlon, William J. and Judith Feder, "The Long-Term Care Marketplace: An Overview," Health Care Financial Management, January 1984.

Scholen, Ken, et. al., The Role of Home Equity in Financing Long-Term Care: A Preliminary Exploration, produced for the Minnesota Housing Finance Agency by the National Center for Home Equity Conversion, Madison, Wisconsin, and the Health Policy Center of Brandeis University, Waltham, Massachusetts, February 28, 1986.

Sekscenski, Edward S., "Discharges From Nursing Homes: Preliminary Data From the 1985 National Nursing Home Survey," NCHS Advancedata, No. 142, September 30, 1987.

Simon, Mitchell M., "Estate Planning and Resource Maximization for the Elderly: Medicaid Considerations," New Hampshire Bar Journal, Volume 25, Number 2, January 1984, pps. 101-108.

Somers, Anne R., "Insurance for Long-Term Care: Some Definitions, Problems, and Guidelines for Action," New England Journal of Medicine, Vol. 317, No. 1, July 2, 1987, pps. 23-29.

Stepankowsky, Paula LaBeck, "Nursing Home Insurance: Seniors Pay Thousands for Policies They Will Never Be Able to Use," The Daily News, Longview, Washington, February 11, 1985.

Strahan, Genevieve, "Nursing Home Characteristics: Preliminary Data From the 1985 National Nursing Home Survey," NCHS Advancedata, No. 131, March 27, 1987.

Tabak, Harley L., "How to Make Sure the Policy Pays," American Health Care Association Journal, Vol. 11, No. 6, October 1985, pps. 20-21.

Talis, William G., "Medicaid as an Estate Planning Tool," Massachusetts Law Review, Spring 1981, pps. 89-94.

Tames, Stephanie, "Special Report: LTC Insurance," Long-Term Care Management Newsletter, Vol. 14, No. 5, March 7, 1985.

Texas State Board of Insurance, The Long-Term Care Dilemma: What Can Be Done About It, Austin, Texas, January 12, 1987.

Topolnicki, Denise M., "When a Nursing Home Becomes Your Poorhouse," Money Magazine, Vol. 15, No. 3, March 1986, pps. 175-182.

United States Code, Congressional and Administrative News, 97th Congress--Second Session--1982, Legislative History

(Public Laws 97-146 to 97-248) Volume 2, St. Paul, Minnesota, West Publishing Company.

United States Congress, House Select Committee on Aging, America's Elderly at Risk, Washington, D.C., United States Government Printing Office, 1985.

United States Congress, House Select Committee on Aging, Long-Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone are at Risk, Committee Publication No. 100-631, U.S. Government Printing Office, Washington, D.C., 1987.

United States Congress, Office of Technology Assessment, Losing a Million Minds: Confronting the Tragedy of Alzheimer's Disease and Other Dementias, OTA-BA-323, Washington, D.C.: United States Government Printing Office, April 1987.

United States Congress, Senate Special Committee on Aging, Aging America: Trends and Projections, 1985-86 Edition, February 5, 1986.

United States Congress, Senate Special Committee on Aging, Aging America: Trends and Projections, 1987-88 Edition.

United States Congress, Senate Special Committee on Aging, How Older Americans Live: An Analysis of Census Data, An Information Paper, Serial No. 99-D, October 1985.

Versnick, Nancy, "'An Idea Whose Time Has Come'," American Health Care Association Journal, Vol. 11, No. 6, October 1985, pps. 36-37.

Villers Foundation, On the Other Side of Easy Street: Myths and Facts About the Economics of Old Age, Washington, D.C., 1987.

Wagner, Lynn, "Nursing Homes Buffeted by Troubles," Modern Health Care, March 18, 1988, pps. 33-42.

Waldo, Daniel, Katharine Levit, and Helen Lazenby, "National Health Expenditures, 1985," Health Care Financing Review, Vol. 8, No. 1, Fall 1986, pps. 1-21.

Walker, David, Deputy Insurance Commissioner of the State of Washington, printed and audio-tape training materials for the Senior Health Insurance Benefits Advisors (SHIBA) Program.

Wasilewski, Charles, "Mature Customers, Immature Products," Best's Review, Vol. 87, No. 12, April 1987.

Weissert, William G., "Estimating the Long-Term Care Population: Prevalence Rates and Selected Characteristics," Health Care Financing Review, Vol. 6, No. 4, Summer 1985, pps. 83-91.

Wiener, Joshua M., "Financing and Organizational Options for Long-Term Care Reform: Background and Issues," unpublished paper presented at the New York Academy of Medicine Annual Health Conference, New York, New York, May 3, 1985.

Wiener, Joshua M., "Modeling Long-Term Care for the Elderly: The Case of Private Insurance," unpublished paper presented at the American Sociological Association Annual Meeting, New York, New York, September 2, 1986.

Wiener, Joshua M., "We Can Run, But We Can't Hide: Financing Options for Long-Term Care," Congressional testimony presented October 1, 1987.

Wiener, Joshua M., Deborah A. Ehrenworth, and Denise A. Spence, "Private Long-Term Care Insurance: Cost, Coverage, and Restrictions," The Gerontologist, Vol. 27, No. 4, 1987, pps. 487-493.

Wiener, Joshua M., et. al., "Money, Money, Who's Got the Money? Financing Options for Long-Term Care," unpublished paper presented at the State University of New York, Albany, conference on "Health in Aging: Sociological Issues and Policy Directions," April 18-19, 1986.

Wiener, Joshua M., et. al., "Who Will Pay for Us When We Are Old and Gray? Financing and Organizational Options for Long-Term Care Reform," unpublished paper presented at the Gerontological Society of America's Annual Meeting, Chicago, Illinois, November 21, 1986.

APPENDIX

Citations for the inset "WHY PEOPLE WITH SIZEABLE ESTATES END UP ON MEDICAID."

[a]"Medicaid is a program intended only for the indigent, and eligibility is contingent on nearly complete depletion of financial resources." (U.S. Congress, Office of Technology Assessment [OTA], p. 26.)

"With some exceptions, to be eligible for Medicaid, an individual must receive or be eligible for federally assisted cash welfare payments." (Council of Economic Advisers, p. 155)

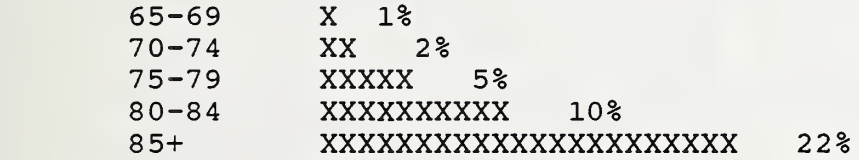
"...the bitter pill of Medicaid coverage for nursing home care is that the recipient must be pauperized, that is, stripped of almost all possessions and other assets, in order to meet eligibility requirements." (Oriol, p. 19)

[b]Council of Economic Advisers, pps. 159-160.

[c]American Council of Life Insurance, mortality tables, p. 113.

[d]"The prevalence of severe dementia [Alzheimer's Disease and related disorders] rises from approximately 1% (ages 65 to 74) to 7% (ages 75 to 84), to 25% (over age 85)." (OTA, p. 7)

[e]Percentages of older Americans living in homes for the aged, by age:



Source: Special Committee on Aging, U.S. Senate. Cited in the Wall Street Journal, December 31, 1986.

"The best estimates place the prevalence of dementia among nursing home residents at more than 50%. By sheer numbers, then, the problems of the long-term care system are the problems of persons with dementia." (OTA, p. 447)

"Five percent of Americans 65 and over are in nursing homes at any one time, but only 3.5% are long-stay patients.... Individuals with dementia are likely to be in the long-stay group, needing supervisory and personal care more than medical attention. One analysis estimates that those with

dementia constitute 60 to 70% of the long-stay group, making dementia one of the major determinants of those staying longer than 90 days in nursing homes." (OTA, p. 27)

"The majority of nursing home admissions are short-stayers (with an average length of stay of 1.8 months), but on any given day, long-stayers (with an average length of stay of 2.5 years) constitute over 90% of all nursing home residents. These long-stayers, who are more likely to be Medicaid recipients, thus consume the vast majority of resident bed days." (HCFA, Grant and Contracts Report, p. 128)

[f]Nursing home expenditures average $22,500 per person annually (OTA, p. 450) and range from $750 per month to over $3,000 (OTA, p. 27).

[g]"Most dementing conditions last years, often decades. One recent study found the average duration of illness, from first onset of symptoms to death, was 8.1 years for Alzheimer's disease...." (OTA, p. 14)

[h]"...those most in need of long-term care are most likely to have the bulk of their savings tied up in their homes. Widows...have 83% of assets thus committed, as compared to a median of 70%." (Oriol, p. 135)

"Based on surveys of elderly living in the community in Massachusetts, 65% of elderly persons aged 66 and older living alone will impoverish themselves after only 13 weeks in a nursing home. For married couples 66 years and older, one out of three (37%) will become impoverished within 13 weeks if one spouse requires nursing home care." (U.S. Congress, House Select Committee on Aging, 1985, p. VII)

[i]"Nursing home care is a small part of Medicare, and the services covered are restricted to short stays after hospitalization.... Nursing home payments under Medicare were only $600 million of $64.6 billion total Medicare outlays in 1984 and accounted for 1.9% of the total spent nationwide on nursing home care." (OTA, p. 18)

[j]"At present, most private insurance simply fills the gaps in Medicare nursing home coverage.... Since insurers rely on the narrow Medicare definition of skilled care, it is not surprising that our national health accounts reveal such a small role for private insurance financing of nursing home care, in spite of the significant number of the elderly who own an insurance policy that covers nursing home care." (Meiners, "The State of the Art in Long-Term Care Insurance," p. 2)

Private insurance of all kinds paid only .85 percent of total nursing home costs in 1985. (HCFA, "Health Care Financing Notes," p. 8)

[k]"The dearth of insurance and Medicare coverage of long-term care (particularly for stays of more than 90 days) is not widely recognized by most older Americans. A survey of elderly people performed by Gallup for the American Association of Retired Persons showed that 79% believed that Medicare would pay for all or part of their nursing home care. Another survey found that only 25% to 47% of those asked knew that Medicare does not cover a 6-month nursing home stay. Yet Medicare covers less than 2% of expenditures for nursing homes, and private insurance pays for less than 1%." (OTA, p. 28)

[l]Private (i.e., nongovernment) sources pay nearly the same proportion of total national health expenditures (58.9 percent) and total nursing home costs (53.1 percent). Overall, health insurance pays 53.3 percent of the private costs. For nursing home costs alone, however, insurance pays only 1.6 percent of private costs. Thus, although the public comes out-of-pocket for only 46.7 percent of private health care costs in general, the elderly direct pay 98.4 percent of private nursing home costs ($18.7 billion). (HCFA, "Health Care Financing Notes," p. 8, based on 1985 data.)

"Although private long-term care financing vehicles, such as long-term care insurance, life care communities, and social HMOs have become increasingly available, the potential market has barely been tapped. There are several factors that inhibit full market development for long-term care financing products.... The key barriers are:

- "The lack of **consumer awareness** about the risk of needing and the cost for long-term care services and the absence of private coverages for these services has suppressed demand for private long-term care financing products....
- "The lack of **data** regarding the utilization and costs of long-term care services, particularly in an insured environment, makes the actuarially sound pricing of products very difficult.
- "The additional **underwriting and policy design** concerns of adverse selection and moral hazard on a product where "medical necessity" may not be an applicable coverage criterion complicates insurer efforts to limit exposure to unpredictable liabilities.

- "The regulatory environment at both state and federal levels presents no incentives for, and in many cases inhibits, long-term care product development.

- "The efficient marketing of long-term care products will require the time-consuming development of new marketing methodologies and systems. The marketing of long-term care products cannot be readily integrated into existing marketing systems of large companies because the target market and the product are so different from most other existing insurance markets and products, and interest by employer groups is limited." (NAIC, p. 15)

"Generally, the Medicaid program is perceived by the middle class as free, acceptable, and an inalienable right.... Until such time as the array of Federal and State programs that currently finance long-term care are perceived as unacceptable alternatives, the private market for long-term care insurance will be limited to those with significant assets to protect and with sufficient income to pay relatively high rates for protecting these assets." (Lifson, "Long-Term Care: An Insurer's Perspective," p. 35)

[m]Some of Medicaid's shortcomings cited by various authors include: (1) the need to spend down assets and income to qualify, (2) the deeming of income provisions which frequently impoverish a well spouse, (3) pressure to divorce in order to partition property, (4) alleged discrimination in the availability of nursing home beds, (5) accusations of inferior care, and (6) welfare stigma. Nevertheless, America's middle class is depending more and more on Medicaid. According to HCFA,

> Medicaid has become the major "insurance" program for nursing home care, not only for elderly persons of low income, but for middle income persons who cannot afford the high cost of nursing homes for very long. (HCFA, Grants and Contracts Report, p. 122)

Unfortunately, Medicaid's contribution to nursing home costs has been declining rapidly and the elderly's out-of-pocket costs have increased proportionately. Between 1979 and 1985, the two major funding sources for nursing home care switched places. Medicaid, which contributed 48.6 percent of total costs ($17.4 billion) in 1979, dropped to 41.8 percent (of $35.2 billion) in 1985. Direct patient payments, i.e., out-of-pocket costs, which were only 42.7 percent in 1979, rose to 51.4 percent in 1985. The contribution of all other funding sources, including Medicare (2.1 percent to 1.7 percent), private health insurance (.8 percent to 1.0 percent), other Government funds (5.2 percent to 3.4

percent), and other private funds (.6 percent to .7 percent), declined from 8.7 percent to 6.8 percent in the same six years. (HCFA, "Health Care Financing Notes," pps. 16-17)

Despite this reversal, "The percentage of United States personal income that is spent on the Medicaid program has...increased from .9 percent in 1973 to 1.2 percent in 1982." (HCFA, Grants and Contracts Report, 1985, p. 13)

[n]The Medicaid income limit varies among States. The figure cited here ($1020 as of 1987) is the maximum allowed in any State except those with "medically needy" programs in which the upper limit is indeterminate. (Neuschler, p. 20)

[o]When one member of an elderly couple, usually the man, becomes ill and requires institutionalization, Medicaid cost sharing rules require that his income, e.g., pensions, social security, etc., must be applied to the cost of care except for an amount equal to poverty level subsistence which remains available to the wife. Income of the well spouse, however, is not deemed available to the institutionalized spouse. Thus, if the person left at home has an independent income source, there may be no problem. As the wife is most likely to remain home the longest and is least likely to have an independent income source, however, she often ends up with too little income to manage. This is the well-known problem of "spousal impoverishment."

[p]"In determining an individual's ownership interest in a jointly held bank account, we apply the legal principle of joint tenancy. This principle provides that joint owners each own all of the funds in the account.... Likewise, under the principles of joint tenancy, all of the funds in a joint bank account are also owned by and available to the ineligible joint owner. For this reason, it would be inappropriate to apply the transfer of resources provision to a withdrawal by an ineligible joint owner since that individual also owns all of the funds. The only instance in which a withdrawal by an ineligible would constitute a transfer would be when the ineligible acts in a legal capacity on behalf of the eligible." (Letter from Rhoda M. G. Davis, Associate Commissioner for Supplemental Security Income, June 24, 1986; constitutes current official HCFA Medicaid eligibility policy.)

[q]Recent law journal articles on public assistance resource avoidance are cited in the Bibliography under the following headings:

_____, "Comments: The Effect of Asset Transfers on Medicaid Eligibility"

American Bar Association

Davis, Clayton

Delbaum, Charles M.

Greenfield, Peter and Barbara A. Isenhour

National Senior Citizens Law Center

Payne, John B., Jr.

Simon, Michell M.

Talis, William G.

[r]"One should not assume that the goal of financial planning for the nursing home patient is immediate Medicaid eligibility. Although State law prohibits nursing homes from discriminating against Medicaid recipients in the admission process, the reality is that many nursing homes juggle their waiting lists in order to violate this provision. It is substantially easier to obtain placement of a patient in a well regarded nursing home if the patient is or appears to be able to pay privately for six months to a year, than if a patient is unable to do so. Therefore, the goal of financial planning may be to leave the potential patient with adequate funds to pay privately for at least six months." (Delbaum, p. 372-373)

[s]"When the home is exempt because it is occupied by a spouse, the institutionalized individual would be well advised to transfer the home to the noninstitutionalized spouse even though this is not necessary to gain immediate Medicaid eligibility. Otherwise, if the noninstitutionalized spouse dies before the institutionalized spouse, or if the non-institutionalized spouse moves elsewhere, the home will lose its character as an exempt resource. It would then have to be sold so that the proceeds can be used to pay for the care of the institutionalized individual. Further, a lien could be placed against it for Medicaid payments made between the time it loses its character as an exempt resource and the time it is sold." (Delbaum, p. 377-378)

CMS LIBRARY
3 8095 00005153 8